Hy-Vee health
INFUSION CARE

DERMATOLOGY
Order Set

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Diagnosis	Infusion Orders	Refills
☐ Cellulitis ☐ MRSA ☐ Skin infection/Abscess **ICD-10:** _____	☐ **Cubicin** ☐ 4 mg/kg IV ☐ 6 mg/kg IV ☐ Daily for _____ days _____ weeks ☐ **Orbactiv** 1200 mg IV x1 dose ☐ **Rocephin** ☐ 1 gm IV ☐ 2 gm IV ☐ Daily for _____ days _____ weeks ☐ **Dalvance** ☐ 1000 mg IV followed 1 week later by 500 mg ☐ 750 mg IV followed 1 week later by 375 mg (CrCl<30) ☐ 1500 mg IV x1 dose ☐ 1125 mg IV x1 dose (CrCl<30)	
☐ Dermatomyositis ☐ Dermatopolymyositis ☐ Phemphigoid/Pemphigus ☐ Other: _____ **ICD-10:** _____	**IVIg** orders: _____ mg/kg **OR** _____ gm/kg IV x _____ day(s) **OR** divided over _____ day(s) **Frequency:** Every _____ weeks x1 year **OR** _____ 1 time dose only Preferred brand: _____ (Hy-Vee Health to choose if not indicated) Additional Ig orders: _____	
☐ CIU **ICD-10:** _____	☐ **Xolair** ☐ 150 mg Sub-Q every 4 weeks ☐ 300 mg Sub-Q every 4 weeks Note: Patient must have an EpiPen in their possession on their appointment date.	
☐ Pemphigus vulgaris **ICD-10:** _____	☐ **Rituximab or rituximab biosimilar** as required by patient's insurance ☐ Do not substitute. Infuse the following rituximab product: _____ *For Hy-Vee Health use only.* Brand: _____ Initial dose: ☐ 1000 mg IV at days 0 and 15 Maintenance dose: ☐ 500 mg IV at month 12 and every 6 months thereafter Other dose: _____ Protocol premedication orders: Solu-Medrol 100 mg IV, Tylenol 1000 mg PO and Benadryl 50 mg PO/IV	
☐ Psoriatic arthritis ☐ Psoriasis ☐ Plaque psoriasis **ICD-10:** _____	☐ **Infliximab or infliximab biosimilar** as required by patient's insurance ☐ Do not substitute. Infuse the following infliximab product: _____ *For Hy-Vee Health use only.* Brand: _____ Dose: _____ mg/kg Frequency: ☐ Every _____ weeks **OR** ☐ weeks 0, 2, and 6, then every 8 weeks **Simponi aria** Initial dose: ☐ 2 mg/kg IV at weeks 0 and 4, then every 8 weeks Maintenance dose: ☐ 2 mg/kg IV every 8 weeks **Stelara** ☐ 45 mg Sub-Q initially and 4 weeks later, followed by 45 mg every 12 weeks (≤ 100kg) ☐ 90 mg Sub-Q initially and 4 weeks later, followed by 90 mg every 12 weeks (>100kg) Maintenance dose: ☐ 45 mg Sub-Q every 12 weeks **OR** ☐ 90 mg Sub-Q every 12 weeks **Ilumya** Initial dose: ☐ 100 mg Sub-Q at weeks 0 and 4, then every 12 weeks thereafter Maintenance dose: ☐ 100 mg Sub-Q every 12 weeks **Cimzia** ☐ 200 mg Sub-Q every 2 weeks ☐ 400 mg Sub-Q every 4 weeks ☐ 400 mg Sub-Q every 2 weeks ☐ 400 mg Sub-Q at weeks 0, 2 and 4, followed by ☐ 200 mg ☐ 400 mg every 2 weeks	

Premedication orders: Tylenol ☐ 1000 mg ☐ 500 mg PO, please choose 1 antihistamine:
☐ Diphenhydramine 25 mg PO ☐ Loratadine 10 mg PO ☐ Cetirizine 10 mg PO ☐ Quzyttir 10 mg IVP
Additional premedications: ☐ Solu-Medrol _____ mg IVP ☐ Solu-Cortef _____ mg IVP ☐ Other: _____
Lab orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____ ☐ Yearly TB QFT (optional)
Required labs to be drawn by: ☐ Hy-Vee Health ☐ Referring Provider

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM

Hy-Vee health INFUSION CARE

COMPREHENSIVE SUPPORT FOR DERMATOLOGY THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy
  - ☐ For biologic orders, has the patient had a documented contraindication/intolerance or failed trial of a conventional therapy (i.e., steroids)?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Stelara, Cimzia)?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ *If applicable* – Last known biological therapy: _____ and last date received: _____. If patient is switching to biologic therapies, please perform a washout period of _____ weeks prior to starting ordered biologic therapy.
- ☐ **Other Medical Necessity:** _____

Required prescreening (based on drug therapy)

- ☐ **TB screening test completed within 12 months – attach results**
  Required for: Cimzia, Infliximab, Stelara, Ilumya, Simponi aria
  - ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM)**
  Required for: Cimzia, Infliximab, Rituximab, Simponi
  - ☐ **Positive** ☐ **Negative**
- ☐ **Baseline creatinine** Required for IVIG

*If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+).

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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