Hy-Vee health
INFUSION CARE

INFLIXIMAB
Infusion Orders

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:** __________

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Patient Weight: ________ lbs.   Allergies: ______________________

Diagnosis: Crohn's disease   Ulcerative colitis   Rheumatoid arthritis   Ankylosing spondylitis

ICD-10: __________   Psoriasis   Other: __________

Therapy Order

Infliximab: *(choose one)*
- Infuse infliximab **OR** infliximab biosimilar as required by patient's insurance
  **Preferred product to be determine after benefits investigation (noted below)
- Do not substitute. Infuse the following infliximab product: ______________________

Dose: __________ mg/kg

Frequency: weeks 0, 2 and 6, then every 8 weeks (initial start) x1 year
Every ________ weeks (maintenance dose) x1 year
Other: ______________________

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 testing QFT (optional)   Required labs to be drawn by: Hy-Vee Health   Referring Physician

Anaphylactic reaction orders:
- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally OR IV (adult)
- NS 0.9% 500 mL IV bolus as needed (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

*For Hy-Vee Health Use Only

Drug/Brand Selection: ______________________

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 ________

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Hy-Vee health INFUSION CARE

COMPREHENSIVE SUPPORT FOR INFLIXIMAB THERAPIES

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

Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID or conventional therapy (i.e., MTX, Leflunomide)?

Yes No

If yes, which drug(s)? ______________________

Does the patient have a contraindication/intolerance or failed trial to at least 1 biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?

Yes No

If yes, which drug(s)? ______________________

If psoriasis diagnosis, percent of body surface (BSA) involved: ____________ %

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 infliximab.

Other Medical Necessity: ______________________

Required Prescreening

TB screening test completed within 12 months – attach results

Positive **Negative**

Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) – attach results

Positive **Negative**

*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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