Hy-Vee health
INFUSION CARE

IRON
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:** _____

Medical Information

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

Primary ICD-10: _____ **Secondary ICD-10:** _____

- ☐ Iron deficiency anemia
- ☐ Iron deficiency unspecified
- ☐ Iron deficiency anemia secondary to inadequate dietary iron intake
- ☐ Other medical necessity: _____

- ☐ Adverse effect of other drug (oral iron intolerance or not adequate)
- ☐ End-stage renal disease
- ☐ Intestinal malabsorption
- ☐ Chronic kidney disease
- ☐ Other medical necessity: _____

Venofer Therapy Order

- ☐ Venofer 200 mg IV – Administer 5 doses over a 14 day period
- ☐ Venofer 200 mg IV weekly x5 weeks
- ☐ Other: _____

Injectafer Therapy Order

****If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.****

☐ **Patient weighing less than 50kg (110 lbs.)**

Dose: Injectafer 15 mg/kg IV

Frequency: Give 2 doses as least 7 days apart, not to exceed 1500 mg

☐ **Patient weighing 50kg (110 lbs.) or greater**

Dose: Injectafer 750 mg IV

Frequency: Give 2 doses as least 7 days apart, not to exceed 1500 mg

Monoferric Therapy Order

****If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.****

☐ **Patient weighing less than 50kg (110 lbs.)**

Dose: Monoferric 20 mg/kg IV x1 dose

☐ **Patient weighing 50kg (110 lbs.) or greater**

Dose: Monoferric 1000 mg IV x1 dose

Other orders: _____

Lab orders: _____ **Frequency:** _____

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® 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Solu-Medrol 125 mg IV as needed (adult), refer to provider orders or policy for pediatric dosing
- NS 250-500 mL IV bolus as needed (adult), refer to provider orders or policy for pediatric bolus

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

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 IRON 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 (H&P) to support primary diagnosis
  - ☐ Does the patient have an intolerance, contraindication or documented tried and failed use of oral iron?
    - ☐ Yes ☐ No
  - ☐ Does the patient have an intolerance or documented tried and failed use of an IV iron product?
    - ☐ Yes ☐ No If yes, which drug(s)? _____
- ☐ Labs showing iron deficiency anemia attached
- ☐ Other Medical Necessity: _____

Required Prescreening

- ☐ **Labs indicating iron deficiency – please attach**

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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