Hy-Vee health
INFUSION CARE

NEPHROLOGY
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	
☐ Iron deficiency anemia ☐ Iron deficiency anemia with CKD not on dialysis (ICD-10 Code:_____)	****If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.**** ☐ **Venofer** 200 mg IV – Administer 5 doses over a 14 day period ☐ **Venofer** 200 mg IV weekly x5 dose ☐ **Injectafer** 15 mg/kg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt <50kg) ☐ **Injectafer** 750 mg IV – Give 2 doses at least 7 days apart, not to exceed 1500 mg (wt ≥50kg) ☐ **Monoferric** 20 mg/kg IV x1 dose (wt <50kg) ☐ **Monoferric** 1000 mg IV x1 dose (wt ≥50kg)	
☐ Chronic gouty arthropathy w/tophus (tophi) ☐ Chronic arthopathy w/o mention of tophus (tophi) (ICD-10 Code:_____)	☐ **Krystexxa** 8 mg IV every 2 weeks **Premedication protocol:** Benadryl 50 mg IV/PO and Solu-Medrol 125 mg IV ☐ Other orders: _____ For Hy-Vee Health to dispense the methotrexate, please check appropriate box: ☐ Methotrexate 15 mg PO weekly x1 year (begin 4 weeks prior to Krystexxa)	**Refills** ☐ _____ ☐ x1 year
☐ X-linked hypophosphatemia (ICD-10 Code: **E83.31**)	****Max dose 90 mg**** **Crysvita** ☐ Adult XLH 1 mg/kg Sub-Q rounded to nearest 10 mg every 4 weeks **Crysvita** ☐ Pediatric XLH 0.8 mg/kg Sub-Q rounded to nearest 10 mg q 2 weeks Other dosage: _____, frequency _____	**Refills** ☐ _____ ☐ x1 year
☐ Diagnosis: _____ (ICD-10 Code:_____)	**Rituximab IV** Dose: ☐ 1000 mg ☐ 375 mg/m² ☐ Other: _____ Frequency: ☐ 1 time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ Other: _____ ☐ May substitute biosimilar per insurance. *For Hy-Vee Health use* – Brand _____ ☐ Do not substitute. Brand: _____ **Premedication protocol:** Benadryl 50 mg IV/PO and Solu-Medrol 100 mg IV	**Refills** ☐ _____ ☐ x1 year
☐ Kidney transplant (ICD-10 Code:_____)	☐ **Nulojix** _____ mg IV q 4 weeks Other: _____	**Refills** ☐ _____ ☐ x1 year
☐ Diagnosis: _____ (ICD-10 Code:_____)	**IVIg:** _____ mg/kg **OR** _____ gm/kg IV x _____ day(s) **OR** divided over _____ day(s) **Frequency:** Every _____ weeks **OR** _____ *(Hy-Vee Health to choose if not indicated)* Preferred brand: _____ Additional Ig orders: _____	**Refills** ☐ _____ ☐ x1 year

Premedication orders: Tylenol ☐ 1000 mg ☐ 500 mg PO, please choose 1 antihistamine:
☐ Diphenhydramine 25 mg PO/IV ☐ 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: _____

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 NEPHROLOGY 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 (attach)**
  - ☐ 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?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
- ☐ Include labs and/or test results to support diagnosis
- ☐ Other medical necessity: _____

Required Information

- ☐ **Baseline serum uric acid and G6PD serum level (Krystexxa)**
- ☐ **CBC, iron, transferrin, ferritin, TIBC (iron)**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) (Rituxan)**
  - ☐ Positive ☐ Negative
- ☐ **Serum phosphorus (Crysvita)**
- ☐ **Nulojix Distribution Program notification (855) 511-6180 – Patient ID#** _____
- ☐ **TB screening test completed within 12 months (Nulojix)**
  - ☐ Positive ☐ Negative
- ☐ **EBV serostatus (Nulojix)**
- ☐ **Creatinine (Ig)**

*If TB or Hep 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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