

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	
Mild hyperemesis (ICD-10: O21.0) Hyperemesis w/metabolic disturbance (ICD-10: O21.1) Other: _____ (ICD-10 Code: _____)	1 liter 2 liters D5 .45 NS IV x1 day 1 liter 2 liters NS IV x1 day 1 liter 2 liters ringers lactate IV x1 day 1 liter 2 liters D5/ringers lactate x1 day	Zofran 4 mg IVP x1 Zofran 8 mg IVP x1 May repeat regimen x _____ days
Iron deficiency anemia Other medical necessity: _____ (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 doses 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)	
Pyelonephritis Complicated UTI Other: _____ (ICD-10 Code: _____)	Rocephin 1 gm IV daily x7 days Rocephin 2 gms IV daily x7 days Ivanz 1 gm IV daily x7 days Other: _____	
Migraines Other: _____ (ICD-10 Code: _____)	Zofran 4 mg IVP x1 Zofran 8 mg IVP x1 Reglan 10 mg IV x1 May repeat migraine regimen x _____ days	Mag sulfate 1 gram IV x1 Depacon 500 mg IV x1 DHE 45 1 mg IV x1 } Non-OB patients
Other: _____ (ICD-10 Code: _____)	Other: _____	

Lab orders: _____ **Lab frequency:** _____

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 _____

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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

Labs attached

CBC, Iron, Ferritin, Transferrin, TIBC (for iron orders) – **attach results**

Baseline LFTs (for Depacon orders) – **attach results** *can draw with first infusion if not available

Other medical necessity: _____

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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