Hy-Vee health INFUSION CARE

RHEUMATOLOGY 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. **Patient Height:** _____ **Allergies:** _____

ICD-10: _____ **Diagnosis:**

☐ Rheumatoid arthritis, unspecified
☐ Unspecified iridocyclitis
☐ Arthropathic psoriasis, unspecified
☐ Rheumatoid arthritis with rheumatoid factor, unspecified
☐ Rheumatoid arthritis without rheumatoid factor, unspecified
☐ Wegener's granulomatosis
☐ Ankylosing spondylitis, unspecified
☐ Gout
☐ Systemic lupus erythematosus
☐ Other: _____

Therapy Order

Drug	Dosing	Refill
Actemra	☐ 4 mg/kg IV every 4 weeks for _____ doses, then followed by 8 mg/kg every 4 weeks thereafter ☐ 4 mg/kg IV every 4 weeks ☐ 8 mg/kg IV every 4 weeks ☐ Other dose: _____ mg IV every 4 weeks	
Cimzia	☐ Initial dose: 400 mg subcutaneously at weeks 0, 2 and 4 Maintenance dose: ☐ 200 mg subcutaneously Q 2 weeks **OR** ☐ 400 mg subcutaneously Q 4 weeks	
Krystexxa	☐ 8 mg IV every 2 weeks	
Immunoglobulin	☐ IV ☐ Sub-Q _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) _____ mg/kg x _____ day(s) **OR** divided over _____ day(s) Brand: _____ (Hy-Vee Health to choose if not indicated) Frequency: Every _____ weeks or _____	
Orencia	Orencia dose: _____ mg IV Frequency: ☐ Every 4 weeks **OR** ☐ weeks 0, 2 and 4, then every 4 weeks thereafter	
Simponi Aria	☐ Initial dose: 2 mg/kg at weeks 0 and 4, then every 8 weeks ☐ Maintenance dose: 2 mg/kg every 8 weeks	
Stelara	Initial dose: ☐ 45 mg subcutaneously initially, 4 weeks later, followed by 45 mg every 12 weeks ☐ 90 mg subcutaneously initially, 4 weeks later, followed by 90 mg every 12 weeks Maintenance dose: ☐ 45 mg subcutaneously every 12 weeks Maintenance dose: ☐ 90 mg subcutaneously every 12 weeks	
Infliximab	Dose: _____ mg/kg Frequency: ☐ Every _____ weeks ☐ weeks 0, 2 and 6,then every 8 weeks ☐ May substitute biosimilar per insurance requirement *For Hy-Vee Health* use. Brand: _____ ☐ Do not substitute. Brand: _____	
Rituximab	Dose: ☐ 1000 mg ☐ Other: _____ ☐ 375 mg/m² Frequency: ☐ 1 time dose ☐ Weekly x4 weeks ☐ Day 0, repeat dose in 2 weeks ☐ May substitute biosimilar per insurance requirement *For Hy-Vee Health* use. Brand: _____ ☐ Do not substitute. Brand: _____	
Saphnelo	☐ 300 mg IV every 4 weeks	

Premedication orders: Tylenol ☐ 1000 mg ☐ 500 mg PO, please choose 1 antihistamine:
☐ Diphenhydramine 25-50 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: _____ ☐ Yearly TB QFT (optional)

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

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COMPREHENSIVE SUPPORT FOR RHEUMATOLOGY 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?
    - ☐ 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: Actemra, Cimzia, Infliximab, Stelara, Simponi Aria, Orencia
  - ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM)**
  Required for: Actemra, Cimzia, Infliximab, Rituximab, Simponi Aria
  - ☐ **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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