Hy-Vee health INFUSION CARE

RITUXIMAB
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) **Patient Height:** _____ inches

Allergies: _____

Diagnosis: ☐ Rheumatoid arthritis ☐ Granulomatosis w/ polyangiitis ☐ Microscopic polyangiitis
☐ Pemphigus vulgaris ☐ Other: _____

ICD-10: _____

Therapy Order

Rituximab: *(choose one)*

☐ Infuse Rituximab **OR** Rituximab biosimilar as required by patient's insurance
**Preferred product to be determine after benefits investigation (noted below)
☐ Do not substitute. Infuse the following Rituximab product _____

Dose: ☐ 1000 mg ☐ 375 mg/m² ☐ 500 mg ☐ Other: _____

Frequency: ☐ One time dose

☐ Day 0, repeat dose in 2 weeks, then repeat course every _____ weeks **OR** _____ months x _____ refill(s)

☐ Day 0, repeat dose in 2 weeks. One time order, do not repeat the course.

☐ Weekly x4 weeks

☐ Every 6 months x _____ refill(s)

☐ Other: _____

Other orders: _____

Protocol premedication orders: Solu-Medrol 100 mg IV, Tylenol 1000 mg PO, Benadryl 50 mg PO/IV

☐ Other: _____

Lab Orders: _____ **Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

For Hy-Vee Health Use Only

Brand: _____

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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COMPREHENSIVE SUPPORT FOR RITUXIMAB 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
  - ☐ Has the patient had a documented contraindication/intolerance or failed trial of a glucocorticoids?
    - ☐ Yes ☐ No
  - ☐ Does the patient have an intolerance or failed trial to a Rituximab biosimilar?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ If appliable: 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)? _____
  - ☐ If applicable: 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)? _____
- ☐ Supporting labs/diagnostics attached
- ☐ *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 Rituximab.
- ☐ Other medical necessity: _____

Required Prescreening

- ☐ **CBC w/platelet**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B surface antigen and Hepatitis B core antibody total (not IgM) – attach results**
  - ☐ **Positive** ☐ **Negative**
- ☐ Recommended labs but not required: Quantitative immunoglobulins

If Hepatitis B results are positive, please provide documentation of medical clearance

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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