Hy-Vee health INFUSION CARE

ALLERGY / IMMUNOLOGY
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:** _____

Therapy Order

Diagnosis	Infusion Orders		Refills
☐ Persistent asthma (ICD-10 Code:_____) ☐ Chronic idiopathic urticaria (ICD-10 Code:_____) ☐ Nasal polyps (ICD-10 Code:_____)	☐ **Xolair** 75 mg Sub-Q ☐ **Xolair** 150 mg Sub-Q ☐ **Xolair** 225 mg Sub-Q ☐ **Xolair** 300 mg Sub-Q ☐ **Xolair** 375mg Sub-Q ☐ **Xolair** 450 mg Sub-Q ☐ **Xolair** 525 mg Sub-Q ☐ **Xolair** 600 mg Sub-Q	**Xolair frequency:** ☐ Every 2 weeks ☐ Every 4 weeks	☐ _____ ☐ x1 year
☐ Severe asthma with eosinophilic phenotype (ICD-10 Code:_____) ☐ Severe granulomatosis with polyangiitis (ICD-10 Code:_____)	☐ **Cinqair** 3 mg/kg IV every 4 weeks ☐ **Fasenra** initial dose: 30 mg Sub-Q every 4 weeks for the first 3 doses, followed by 30 mg Sub-Q every 8 weeks there after ☐ **Fasenra** 30 mg Sub-Q every 8 weeks ☐ **Nucala** 100 mg Sub-Q every 4 weeks ☐ **Nucala** 300 mg Sub-Q every 4 weeks ☐ **Tezspire** 210 mg Sub-Q every 4 weeks		☐ _____ ☐ x1 year
☐ Common variable immunodeficiency (ICD-10 Code:_____) ☐ Other: _____ (ICD-10 Code:_____)	**Immunoglobulin:** ☐ **IV** ☐ **Sub-Q** _____ mg/kg **OR** _____ gm/kg x _____ day(s) **OR** divided over _____ day(s) **Frequency:** Every _____ weeks **OR** _____ *(Hy-Vee Health to choose if not indicated)* Brand: _____ Additional Ig orders: _____		☐ _____ ☐ x1 year

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

HY-VEEHEALTHINFUSION.COM

Hy-Vee health INFUSION CARE

COMPREHENSIVE SUPPORT FOR ALLERGY / IMMUNOLOGY THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing and 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
  - ☐ Please indicate any tried and failed therapies (if applicable):
    - ☐ Corticosteroids _____
    - ☐ Long-acting beta 2 agonist _____
    - ☐ Long-acting muscarinic antagonist _____
    - ☐ Immunosuppressants (EGPA) _____
  - ☐ *Asthma* – Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No
  - ☐ *Asthma* – Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No
  - ☐ *PI* – Documentation of recurrent bacterial infections, history of failure to respond to antibiotics, documentation of pre and post pneumonococcal vaccine titers
- ☐ Include labs and/or test results to support diagnosis **(attach results)**
  - ☐ Does patient have a baseline peripheral blood eosinophil level of ≥150 cells/mcL within the past 6 weeks (asthma and EGPA) or ≥1000 cells/mcL within 4 weeks (HES)? ☐ Yes ☐ No
  - ☐ FEV1 score (if applicable): _____
  - ☐ Serum IgE level – *for asthma and nasal polyps Xolair*
  - ☐ Skin/RAST test – *for asthma Xolair*
  - ☐ Serum immunoglobulins – *for Ig*
  - ☐ Serum creatinine – *for Ig*
  - ☐ CBC w/differential – *for Fasenra, Nucala, Cinqair*
- ☐ If injection order, is the patient or caregiver not competent or physically unable to administer the product for self-administration? ☐ Yes ☐ No
- ☐ Xolair – Patient has Epi pen prescribed
- ☐ 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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