Hy-Vee health INFUSION CARE

GASTROENTEROLOGY 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	Refills
☐ Dehydration ☐ Diverticulitis ☐ Gastroenteritis **ICD-10:** _____	☐ 1 Liter ☐ 2 Liters D5 .45 NS IV x1 day ☐ 1 Liter ☐ 2 Liters NS IV x1 day ☐ Other: _____	
☐ Iron Deficiency anemia ☐ Iron Deficiency anemia with CKD not on dialysis **If the patient has Aetna, Cigna, Humana or UHC, the patient must try and fail Venofer first.** **ICD-10:** _____	☐ **Venofer** 200 mg IV – Administer 5 doses over a 14 day period ☐ **Venofer** 200 mg IV weekly x5 weeks ☐ **Injectafer** 15 mg/kg IV (<50kg) – Give 2 doses at least 7 days apart ☐ **Injectafer** 750 mg IV (≥50kg) – Give 2 doses at least 7 days apart ☐ **Monoferric** 1000 mg IV x1 dose (≥50kg) ☐ **Monoferric** 20 mg/kg IV x1 dose (<50kg)	
☐ Crohn's disease ☐ Ulcerative colitis ☐ Other: _____ **ICD-10:** _____	☐ **Cimzia** 400 mg Sub-Q at weeks 0, 2 and 4, then every 4 weeks ☐ **Cimzia** _____ mg Sub-Q every _____ weeks ☐ **Infliximab or infliximab biosimilar** as required by patient's insurance ☐ Do not substitute. Infuse the following infliximab product: _____ *For Hy-Vee Health use only.* Brand: _____ Dose: _____ mg/kg Frequency: ☐ Every _____ weeks **OR** ☐ weeks 0, 2 and 6, then every 8 weeks **Skyrizi** Initial infusion: 600 mg IV at week 0, 4 and 8 weeks **Skyrizi** maintenance: 360 mg Sub-Q at week 12, then every 8 weeks thereafter (to be evaulated by Hy-Vee Health) **Stelara** Initial infusion: ☐ <55kg – 260 mg IV x1 dose ☐ 55kg to 85kg – 390 mg IV x1 dose ☐ >85kg – 520 mg IV x1 dose **Stelara** Maintenance: ☐ 90 mg Sub-Q 8 weeks after initial infusion, then every 8 weeks **Tysabri** 300 mg IV every 4 weeks **Entyvio** 300 mg IV at weeks 0, 2 and 6, then Q8 weeks 300 mg IV every 8 weeks	☐ _____ ☐ 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: _____ ☐ Yearly TB QFT (optional)

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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COMPREHENSIVE SUPPORT FOR GASTROENTEROLOGY 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., 6MP, azathioprine)?
    - ☐ Yes ☐ No
    - If yes, which drug(s)? _____
  - ☐ For biologic orders, does the patient have a contraindication/intolerance or failed trial to any other biologic (i.e., Humira, Stelara, Cimzia)?
    - ☐ 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: Cimzia, Infliximab, Stelara, Entyvio, Skyrizi
  ☐ **Positive** ☐ **Negative**
- ☐ **Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) – attach results**
  Required for: Cimzia, Infliximab
  ☐ **Positive** ☐ **Negative**
- ☐ **JCV antibody & TOUCH authorization**
  Required for Tysabri
  ☐ **Positive** ☐ **Negative**
- ☐ **Labs indicating iron deficiency** Required for Venofer, Injectafer, Monoferric

*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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