Hy-Vee health INFUSION CARE

HOME PARENTERAL NUTRITION (TPN) Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Name: _____	☐ Demos attached	Line Access
DOB: _____		☐ Port ☐ PICC ☐ Other
Sex: ☐ Male ☐ Female		Lumens: ☐ 1 ☐ 2 ☐ 3
Weight: _____ ☐ lbs ☐ kg	**Height:** _____	☐ Central Line needed

Order Information

Diagnosis/Indication for TPN therapy: _____ Date: _____

Rx Order: Hy-Vee Health to provide Home Parenteral Nutrition (PN)/TPN Therapy

TPN Management – For Custom Consult, Check the Box

☐ Check Please

The Hy-Vee Health Support Team will provide evidence-based, customized home PN management to optimize patient outcomes. Checking the box authorizes Hy-Vee Health to assess and write orders for the initial TPN formula and to make ongoing changes to the TPN prescription, including adjustments to electrolytes and macronutrients, volume and daily infusion duration, lab order management and home health coordination with subsequent notification to the treating provider.

Treating provider managed TPN – Hy-Vee Health will not provide recommendations for changes. Please include your custom order form.

Required Information

Length of Need Statement (LON)

- MUST be included in a progress note and signed by the prescriber
- Example of LON: "Due to patient's [condition], TPN is needed for [insert amount of time here]."
- Medicare requires patient to have a permanent impairment considered long and indefinite in duration
- Note: Medicare does recognize time frames such as "lifetime" as appropriate

Must also include enteral contraindication

- What prevents patient from having a feeding tube?

Provider 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, and to select the preferred site of care for the patient.

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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