Hy-Vee health INFUSION CARE

ALLERGY & IMMUNOLOGY Order Form

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

☐ **Demographics Attached**

Patient Name: _____ **DOB:** _____ **Phone:** _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Patient Weight: _____ lbs. (required) **Allergies:** _____

Diagnosis: _____ **ICD-10 Code:** _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

History of Asthma (Xolair): Positive Skin or RAST Test: ☐ Yes ☐ No ***Required for Asthma* Test Date: _____

Pre-Treatment IgE Serum: _____ IU/ml ***Required for Asthma and Nasal Polyp* Test Date: _____ Date of Last Xolair Dose: _____

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Required Labs: ☐ CBC with differential (Cinqair, Fasenra, and Nucala) ☐ BMP or Cr (IVIG)

Lab Orders: _____

NOTE: Patient must have their EpiPen in their possession at every Xolair appointment.

Infusion Orders

DIAGNOSIS	INFUSION ORDERS	REFILLS
☐ Persistent asthma ICD-10: _____ ☐ Chronic idiopathic urticaria ICD-10: _____ ☐ Nasal polyps ICD-10: _____	☐ Xolair 150 mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ Xolair 225 mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ Xolair 300 mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ Xolair 375 mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months ☐ Xolair _____ mg Sub-Q every ☐ 2 weeks or ☐ 4 weeks for _____ months	☐ _____ ☐ x1 year
☐ Severe asthma with eosinophilic phenotype ICD-10: _____ ☐ Eosinophilic granulomatosis with polyangiitis ICD-10: _____	☐ **Cinqair** 3 mg/kg IV every 4 weeks for _____ months ☐ **Fasenra** initial dose: 30 mg Sub-Q every 4 weeks for the first 3 doses followed by 30 mg Sub-Q every 8 weeks thereafter for _____ months ☐ **Fasenra** maintenance dose: 30 mg Sub-Q every 8 weeks for _____ months ☐ **Nucala** 100 mg Sub-Q every 4 weeks for _____ months ☐ **Nucala** 300 mg Sub-Q every 4 weeks for _____ months	☐ _____ ☐ x1 year
☐ Common variable immunodeficiency ICD-10: _____ ☐ Other: _____ ICD-10: _____	IVIG Brand: ☐ Bivigam ☐ Carimune _____ % ☐ CytoGam ☐ Flebogamma 5% ☐ Flebogamma 10% ☐ Gammagard ☐ Gammaked ☐ Gammaplex ☐ Gamunex C ☐ Octagam ☐ Panzyga ☐ Privigen IVIG Pre-Medication Orders: ☐ Tylenol 1000 mg Antihistamine: ☐ Cetirizine 10 mg PO ☐ Diphenhydramine 25 mg PO ☐ Loratadine 10 mg PO Additional Pre-Medication Orders: ☐ Solu-Medrol _____ Mg IVP ☐ NS 0.9% _____ mL IV ☐ **IVIG** Order: _____ mg/kg IV over _____ day(s) ☐ **IVIG** Order: _____ mg/kg IV over _____ day(s) Frequency: ☐ Every _____ weeks for _____ months or ☐ One-time dose ONLY	☐ _____ ☐ x1 year

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:** _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX ☐ Phoenix, AZ ☐ Other _____

HY-VEEHEALTHINFUSION.COM