InfuCare Rx

Rheumatology Infusion Referral Form

of Pages Faxed:_____
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required:_____ Ship To: ☐ Home ☐ Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Alternate Phone:_____
Date of Birth:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:_____ ID:_____ Group:_____
Secondary Insurance:_____ ID:_____ Group:_____
Prescription Card:_____ ID:_____ BIN:_____ PCN:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS/CLINICAL INFORMATION

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.10 Systemic Lupus Erythematosus
☐ K50.00 Crohn's Disease
☐ Other:_____

Prior Medication Failed:_____
Length of Treatment:_____
Reason for Discontinuation:_____

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read:_____
Patient Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in
Allergies:_____
Lab Data:_____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Actemra®		Infuse: ☐ 80mg ☐ 200mg ☐ 400mg every 4 weeks	1 month supply	
☐ Benlysta®	☐ 120mg/vial ☐ 400mg/vial	☐ Loading Dose: Infuse _____ mg at weeks 0,2,and 4 ☐ Maintenance Dose: Infuse _____ mg every 4 weeks	4 week supply	
☐ Boniva®	☐ 3mg/ml	☐ Inject 3mg every 3 months	1 month supply	
☐ Cimzia®	☐ 200mg/vial	☐ Infuse _____	1 month supply	
☐ Krystexxa®	☐ 8mg vial	☐ Infuse _____	1 month supply	
☐ Orencia®	☐ 250mg vial	☐ Infuse _____	1 month supply	
☐ Reclast®	☐ 5mg/100ml	☐ Infuse _____	1 month supply	
☐ Remicade®	☐ 100mg vial	☐ Infuse _____	1 month supply	
☐ Rituxan®	☐ 100mg vial ☐ 500mg vial	☐ Infuse _____	1 month supply	
☐ Simponi Aria®	☐ 50mg/4ml	☐ Infuse _____	1 month supply	
☐ Other:				

ADDITIONAL ORDERS

Prescriber Signature:_____ **Date:**_____ **UPIN:**_____