

Date Required: _____ Ship To: Patient MD Office Other: _____

PATIENT INFORMATION

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Date of Birth: _____ Male Female
 Emergency Contact: _____ Phone: _____

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:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

L40.50 Psoriatic Arthritis
 L40.0 Moderate to Severe Plaque Psoriasis
 L73.2 Hidradenitis
 Other: _____
 Prior Medication Failed: _____
 Length of Treatment: _____
 Reason for Discontinuation: _____

TB/PPD test: Positive Negative Date Read: _____
 Location: Hands Feet Scalp Groin
 Nails Other: _____
 Weight: _____ kg lbs Height: _____ cm in %BSA: _____
 Allergies: _____ NKDA
 Injection Training/Home Health RN visit is necessary. Yes No
 Site of Care: Home MD Office Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200mg X2 PFS	<input type="checkbox"/> Inject 400mg SC at weeks 0, 2, and 4 <input type="checkbox"/> Inject 400mg once monthly <input type="checkbox"/> Inject 200mg every other week	1 month supply	
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> 300mg (2x150) Pen <input type="checkbox"/> PFS <input type="checkbox"/> 150mg Pen <input type="checkbox"/> PFS	<input type="checkbox"/> Load: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC week 0,1,2,3,4 <input type="checkbox"/> Maintenance: Inject <input type="checkbox"/> 300mg or <input type="checkbox"/> 150mg SC every 4 weeks	5 week supply 4 week supply	
<input type="checkbox"/> Dupixent®	<input type="checkbox"/> 300mg/2ml PFS	<input type="checkbox"/> Inject 600mg (two 300mg injections in different injection sites) SC on day 0, then 300mg day 14 and day 28 <input type="checkbox"/> Inject 300mg SC every other week	1 month supply	
<input type="checkbox"/> Enbrel®	<input type="checkbox"/> 50mg Sureclick <input type="checkbox"/> 25mg Vials <input type="checkbox"/> 50mg PFS <input type="checkbox"/> 25mg PFS	<input type="checkbox"/> Inject 50mg once weekly <input type="checkbox"/> Inject 50mg twice weekly <input type="checkbox"/> Inject 25mg twice weekly	1 month supply	
<input type="checkbox"/> Humira®	<input type="checkbox"/> 40mg Pen <input type="checkbox"/> 40mg PFS	<input type="checkbox"/> Inject 40mg SC once a week <input type="checkbox"/> Inject 40mg SC every other week <input type="checkbox"/> Inject 80mg day 1, then 40mg day 8, then 40mg every other week <input type="checkbox"/> Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 40mg every week	1 month supply	
<input type="checkbox"/> Otezla®	<input type="checkbox"/> 30mg tablet <input type="checkbox"/> Starter Pack	<input type="checkbox"/> Take 1 tablet by mouth once daily <input type="checkbox"/> Take 1 tablet by mouth twice daily <input type="checkbox"/> Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 50mg Smartject <input type="checkbox"/> 50mg PFS	<input type="checkbox"/> Inject 50mg SC once monthly	1 month supply	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg PFS <input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Inject 45mg day 1 and week 4, then every 12 weeks <input type="checkbox"/> Inject 45mg every 12 weeks <input type="checkbox"/> Inject 90mg day 1 and week 4, then every 12 weeks <input type="checkbox"/> Inject 90mg every 12 weeks	1 month supply	
<input type="checkbox"/> Tremfya™	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> Inject 100mg SC on week 0 and week 4 <input type="checkbox"/> Inject 100mg SC every 8 weeks	1 month supply	
<input type="checkbox"/> Other:				

By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

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