InfuCare Rx

Rheumatology Subcutaneous Referral Form

of Pages Faxed: _____
Fax Referral To: 877-277-9155
Phone: 877-828-3940

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

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.10 Systemic Lupus Erythematosus
☐ L40.50 Psoriatic Arthritis
☐ Other: _____

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

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: _____
Forteo T-score: _____ Type: _____ Date: _____ Site: _____
Fractured: _____ Date: _____
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:
☐ Actemra®	☐ 162mg PFS	☐ Inject 162mg every other week (under 100kg) ☐ Inject 162mg every week (over 100kg)	1 month supply	
☐ Benlysta®	☐ 200mg Autoinjector ☐ 200mg PFS	☐ Inject 200mg subcutaneously ONCE a week	4 week supply	
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS	☐ Load: Inject ☐ 300mg or ☐ 150mg SC week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SC every 4 weeks	5 week supply 4 week supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 25mg Vials ☐ 50mg PFS ☐ 25mg PFS ☐ Mini™ with Autotouch™	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg once weekly ☐ Inject 25mg twice weekly	1 month supply	
☐ Forteo®	☐ 750µg/3ml pen and supplies	☐ Inject 20 µg SC once daily	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SC once a week ☐ Inject 40mg SC every other week	1 month supply	
☐ Kevzara®	☐ 150mg PFS ☐ 200mg PFS	☐ Inject one PFS SC every 2 weeks	1 month supply	
☐ Methotrexate	☐ 2.5mg tab ☐ 25mg/ml vial	☐ Take _____mg by mouth once weekly ☐ Inject _____mg SC once weekly	1 month supply	
☐ Orencia®	☐ 125mg PFS ☐ 250mg Vial	☐ Inject 125mg once weekly ☐ Inject _____mg once monthly	1 month supply	
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth twice daily ☐ Take as per package instructions	1 month supply	
☐ Otrexup®	☐ _____mg/0.4ml	☐ Inject _____mg once weekly	1 month supply	
☐ Rasuvo®	☐ _____mg	☐ Inject _____mg once weekly	1 month supply	
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SC once monthly	1 month supply	
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 1 and week 4, then inject 45 every 12 weeks ☐ Inject 90mg day 1 and week, then inject 90mg every 12 weeks	1 month supply	
☐ Xeljanz®	☐ 5mg tablet ☐ XR 11mg tablet	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth once daily	1 month supply	
☐ 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:** _____