

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**

K50.00 Crohn's Disease  
 K51.90 Ulcerative Colitis  
 Other: \_\_\_\_\_

Prior Medication Failed: \_\_\_\_\_  
 Length of Treatment: \_\_\_\_\_  
 Reason for Discontinuation: \_\_\_\_\_

TB/PPD test:  Positive  Negative  Date Read: \_\_\_\_\_  
 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:	Refills:
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) <input type="checkbox"/> MAINTENANCE: Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
<input type="checkbox"/> Entyvio®	<input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1)	
<input type="checkbox"/> Humira® <input type="checkbox"/> Humira® Citrate Free	<input type="checkbox"/> Crohn's/UC Starter Package <input type="checkbox"/> 40 mg Pen <input type="checkbox"/> 40 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 160 mg (4 pens) SQ on day 1, then 80 mg (two pens) day 15, then maintenance dosing (1 Package) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ (1pen) every other week (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 40 mg SQ (1 prefilled syringe) every other week (Quantity: 3)	
<input type="checkbox"/> Inflectra®	<input type="checkbox"/> 100 mg vial	<input type="checkbox"/> INITIAL: Infuse IV at 5 mg/kg (Dose = _____ mg) at 0, 2 and 6 weeks. <input type="checkbox"/> MAINTENANCE: IV at 5 mg/kg (Dose = _____ mg) every 8 weeks. <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Remicade®	<input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Infuse _____ mg IV on day 0, 14, and 42 (Quantity: _____) <input type="checkbox"/> MAINTENANCE: Infuse _____ mg IV every 8 weeks (Quantity: _____)	
<input type="checkbox"/> Renflexis™	<input type="checkbox"/> 100 mg vial	<input type="checkbox"/> INITIAL: Infuse IV at 5 mg/kg. Dose = _____ mg at 0, 2 and 6 weeks. <input type="checkbox"/> MAINTENANCE: IV at 5 mg/kg. Dose = _____ mg every 8 weeks. <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg SmartJect® Pen <input type="checkbox"/> 100 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 200 mg SQ on day 0, then 100 mg on day 14 (Quantity: 3) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 4 weeks (Quantity: 1)	
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 130 mg/26mL Vials <input type="checkbox"/> Pre-filled Syringe Weight Required: _____	<input type="checkbox"/> INITIAL: Weight based dosing, infuse IV up to 55 kg = 260 mg (2 vials), > 55 kg to 85 kg = 390 mg (3 vials), > 85 kg = 520 mg (4 vials) <input type="checkbox"/> MAINTENANCE: Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 10 mg Tablets <input type="checkbox"/> 5 mg Tablets <input type="checkbox"/> 10 mg Tablets	<input type="checkbox"/> INITIAL: Take 10 mg PO twice daily (Quantity: 60 with 1 refill) <input type="checkbox"/> MAINTENANCE: Take 5 mg PO twice daily (Quantity: 60) <input type="checkbox"/> MAINTENANCE: Take 10 mg PO twice daily (Quantity 60)	
<input type="checkbox"/> Other:			

**Pre-Medications & Other Medications**

▶ Infusion supplies as per protocol  
 ▶ Anaphylaxis Kit as per protocol

Acetaminophen \_\_\_\_\_ mg PO prior to infusion  
 Diphenhydramine \_\_\_\_\_ mg  
 250ml 0.9% NaCl for hydration  PO  IV  
 Other: \_\_\_\_\_

**Flush Protocol**

▶ NaCl 0.9% 10ml  
 ▶ Before and after infusion

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:** \_\_\_\_\_

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