

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	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

<input type="checkbox"/> K50.00 Crohn's Disease <input type="checkbox"/> K51.90 Ulcerative Colitis <input type="checkbox"/> Other: _____	TB/PPD test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Date Read: _____ Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Height: _____ <input type="checkbox"/> cm <input type="checkbox"/> in %BSA: _____ Allergies: _____ <input type="checkbox"/> NKDA Injection Training/Home Health RN visit is necessary. <input type="checkbox"/> Yes <input type="checkbox"/> No Site of Care: <input type="checkbox"/> Home <input type="checkbox"/> MD Office <input type="checkbox"/> Other: _____
Prior Medication Failed: _____	
Length of Treatment: _____	
Reason for Discontinuation: _____	

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Refills:
<input type="checkbox"/> Cimzia®	<input type="checkbox"/> 200 mg prefilled syringe <input type="checkbox"/> 200 mg vial	<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"/> 300 mg vial	<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 prefilled syringe	<input type="checkbox"/> INITIAL: Inject 160 mg (4 pens) SQ on day 1, then 80 mg (two pens) day 15, then maint. dose (1 pkg) <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 _____ mg/kg (Dose _____ mg) at 0, 2, and 6 weeks (Quantity: _____) <input type="checkbox"/> MAINTENANCE: Infuse IV _____ mg/kg (Dose _____ mg) every _____ weeks (Quantity: _____) <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Remicade®			
<input type="checkbox"/> Renflexis™		<input type="checkbox"/> Pharmacist will round to the nearest 100 <input type="checkbox"/> Give exact dose (do NOT round)	
<input type="checkbox"/> Simponi®	<input type="checkbox"/> 100 mg SmartJect® Pen <input type="checkbox"/> 100 mg prefilled 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"/> 90 mg (2x 45 mg vials)	<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	
<input type="checkbox"/> Xeljanz®	<input type="checkbox"/> 10 mg tablets <input type="checkbox"/> _____ mg tablets	<input type="checkbox"/> INITIAL: Take 10 mg PO twice daily (Quantity: 60 with 1 refill) <input type="checkbox"/> MAINTENANCE: Take _____ mg PO twice daily (Quantity: 60)	
<input type="checkbox"/> Other:			

Pre-Medications & Other Medications ▶ Infusion supplies as per protocol ▶ Anaphylaxis Kit as per protocol	<input type="checkbox"/> Acetaminophen _____ mg PO prior to infusion <input type="checkbox"/> Diphenhydramine _____ mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> 250ml 0.9% NaCl for hydration <input type="checkbox"/> Other: _____	Flush Protocol ▶ NaCl 0.9% 10ml ▶ Before and after infusion
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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:** _____

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