InfuCare Rx

Neurology Injectable Referral Form

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

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: ____________ ☐ Male ☐ 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

☐ Diagnosis and ICD10: ____________
Has the patient been treated for this condition previously? ☐ Yes ☐ No
Is the patient currently on therapy? ☐ Yes ☐ No
What other medications has the patient tried and failed? ____________

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:
☐ AJOVY™	☐ 225mg ☐ 675mg	☐ Inject 225mg SUBQ once monthly ☐ Inject 675mg SUBQ quarterly *(3 - 225mg injections consecutively every 3 mos.)*	1 month supply 3 month supply	
☐ Avonex®	☐ 30mcg PFS ☐ 30mcg vial ☐ 30mcg Pen	☐ Initial: Avostartgrip (Week 1: 7.5mcg, Week 2: 15mcg, Week 3: 22.5mcg, Week 4: 30mcg) ☐ Maintenance: Inject 30mcg IM once weekly ☐ Other: ____________	1 month supply	
☐ AIMOVIG®	☐ 70mg ☐ PFS ☐ 140mg ☐ Pen	☐ Inject 70mg SUBQ once monthly ☐ Inject 140mg SUBQ once monthly *(2 - 70mg injections consecutively)*	1 month supply	
☐ Betaseron®	☐ 0.3 mg PFS	☐ Initial: Week 1&2: 0.25ml (0.0625mg), Week 3&4: 0.5ml (0.125mg) Week 5&6: 0.75ml (0.1875mg), Week 7+ 1ml (0.25mg) SUBQ every other day ☐ Maintenance: Inject 1ml (0.25mg) SUBQ every other day	1 month supply	
☐ Copaxone®	☐ 20mg PFS ☐ 40mg PFS	☐ Inject 20mg SUBQ every day ☐ Inject 40mg SUBQ 3 times weekly	1 month supply	
☐ Extavia®	☐ 0.3mg Kit	☐ Inject 0.25mg SUBQ every other day	1 month supply	
☐ Gilenya™	☐ 0.5mg cap	☐ Take 1 capsule by mouth once daily	1 month supply	
☐ Glatopa™	☐ 20mg PFS ☐ 40mg PFS	☐ Inject 20mg SUBQ every day ☐ Inject 40mg SUBQ 3 times weekly	1 month supply	
☐ Rebif® ☐ Rebidose®	☐ Titration Pack ☐ 22mcg PFS ☐ 44mcg PFS	☐ Initial: Week 1&2: 0.2ml (8.8mcg), week 3&4: 0.5ml (22mcg) SUBQ three times weekly ☐ Maintenance: Inject 0.5ml (22mcg) SUBQ three times weekly ☐ Maintenance: Inject 0.5ml (44mcg) SUBQ three times weekly ☐ Other: ____________	1 month supply	
☐ Epipen® ☐ Epipen® Jr	☐ 2 pack	☐ 1 pen into thigh in case of anaphylaxis	1 box of 2	
☐ 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:** ____________

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