InfuCare Rx

Rheumatology IV Infusion 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
- ☐ M32.9 Systemic Lupus Erythematosus
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis
- ☐ L40.0 Moderate to Severe Plaque Psoriasis
- ☐ L40.50 Psoriatic Arthritis
- ☐ L40.59 Psoriasis with Arthropathy
- ☐ Other: ____________

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: ____________
Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in %BSA: ______
Allergies: ____________ ☐ NKDA
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary:
Reason: ☐ MD office to administer to patient
☐ Home health nursing already coordinated

Prior Medication Failed: ____________ Length of Treatment: ________ Reason for Discontinuation: ____________

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Actemra®	☐ 80 mg per 4mL ☐ 200 mg per 10mL ☐ 400 mg per 20mL	☐ Induction Dose: Infuse 4 mg per kg every 4 weeks ☐ Maintenance Dose: Infuse up to 8 mg per kg every 4 weeks based on clinical response ☐ Other: ____________		
☐ Benlysta®	☐ 120mg per vial ☐ 400mg per vial	☐ Induction Dose: 10mg per kg. Dose = ________ mg at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour ☐ Maintenance Dose: 10mg per kg. Dose = ________ mg every 4 weeks. Infuse IV over 1 hour		
☐ Orencia®	☐ 250mg vial	☐ Infuse ________ mg at weeks 0, 2 and 4, then every 4 weeks thereafter ☐ Other: ____________		
☐ Inflectra® ☐ Remicade® ☐ Renflexis™	☐ 100 mg vial	☐ **INITIAL:** Infuse IV _______ mg per kg (Dose ________mg) at 0, 2, and 6 weeks (Quantity: _______) ☐ **MAINTENANCE:** Infuse IV _______ mg per kg (Dose _______ mg) every ______ weeks (Quantity: ________) ☐ Other: ____________ ☐ Pharmacist will round to the nearest 100 ☐ Give exact dose (do NOT round)		
☐ Rituxan®	☐ 100mg vial ☐ 500mg vial	☐ Infuse two doses of 1000 mg separated by 2 weeks ☐ Other: ____________		
☐ Simponi Aria®	☐ 50mg per 4mL	☐ Infuse 2 mg per kg over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter ☐ Other: ____________		
☐ 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:** ____________

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