InfuCare Rx

Rheumatology Subcutaneous Referral Form

of Pages Faxed: ____________
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required: ____________ Ship To: ☐ Patient ☐ MD Office ☐ Other: ____________

Patient Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________
Cell Phone: ____________
Date of Birth: ____________ ☐ Male ☐ Female
Emergency Contact: ____________ Phone: ____________

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 SUBQ ONCE a week	4 week supply	
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SUBQ 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 SUBQ week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SUBQ 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 per 3mL pen and supplies	☐ Inject 20 µg SUBQ once daily	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SUBQ once a week ☐ Inject 40mg SUBQ every other week	1 month supply	
☐ Kevzara®	☐ 150mg PFS ☐ 200mg PFS	☐ Inject one PFS SUBQ every 2 weeks	1 month supply	
☐ Methotrexate	☐ 2.5mg tab ☐ 25mg per mL vial	☐ Take _____mg by mouth once weekly ☐ Inject _____mg SUBQ 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 per 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 SUBQ 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:** ____________

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