# InfuCare Rx

# Rheumatology Subcutaneous Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

✂ Please cut along the dotted lines before submitting to a pharmacy.

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

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
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
☐ M32.10 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)<br>☐ Inject 162mg every week (over 100kg) | 1 month supply | |
| ☐ Benlysta® | ☐ 200mg Autoinjector<br>☐ 200mg PFS | ☐ Inject 200mg SUBQ ONCE a week | 4 week supply | |
| ☐ Cimzia® | ☐ 200mg X2 PFS | ☐ Inject 400mg SUBQ at weeks 0, 2, and 4<br>☐ Inject 400mg once monthly<br>☐ Inject 200mg every other week | 1 month supply | |
| ☐ Cosentyx® | ☐ 300mg (2x150) Pen ☐ PFS<br>☐ 150mg Pen ☐ PFS | ☐ Load: Inject ☐ 300mg or ☐ 150mg SUBQ week 0,1,2,3,4<br>☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SUBQ every 4 weeks | 5 week supply<br>4 week supply | |
| ☐ Enbrel® | ☐ 50mg Sureclick ☐ 25mg Vials<br>☐ 50mg PFS ☐ 25mg PFS<br>☐ Mini™ with Autotouch™ | ☐ Inject 50mg once weekly<br>☐ Inject 50mg twice weekly<br>☐ Inject 25mg once weekly<br>☐ 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<br>☐ 40mg PFS | ☐ Inject 40mg SUBQ once a week<br>☐ 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<br>☐ 25mg per mL vial | ☐ Take _____mg by mouth once weekly<br>☐ Inject _____mg SUBQ once weekly | 1 month supply | |
| ☐ Orencia® | ☐ 125mg PFS<br>☐ 250mg Vial | ☐ Inject 125mg once weekly<br>☐ Inject _____mg once monthly | 1 month supply | |
| ☐ Otezla® | ☐ 30mg tablet<br>☐ Starter Pack | ☐ Take 1 tablet by mouth twice daily<br>☐ 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<br>☐ 90mg PFS | ☐ Inject 45mg day 1 and week 4, then inject 45 every 12 weeks<br>☐ Inject 90mg day 1 and week, then inject 90mg every 12 weeks | 1 month supply | |
| ☐ Xeljanz® | ☐ 5mg tablet<br>☐ XR 11mg tablet | ☐ Take 1 tablet by mouth twice daily<br>☐ Take 1 tablet by mouth once daily | 1 month supply | |
| ☐ Other: | | | | |

*By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.*

**Prescriber Signature:** _____ **Date:** _____

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