InfuCare Rx®

Humira® 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 INF ORMATION

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

☐ L20.89 Atopic Dermatitis
☐ L73.2 Hidradenitis
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ M06.9 Rheumatoid
☐ Other: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____
Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____
☐ PHOTOTHERAPY UVA/UVB Failed:
Length of Treatment: _____
Reason for Discontinuation: _____

☐ Patient Cannot Afford ☐ Photosensitivity ☐ Risk of skin cancer ☐ Distance from office

TB/PPD test: ☐ Positive ☐ Negative ☐ Date Read: _____
Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Face ☐ Nails ☐ Other: _____

American Academy Of Dermatology Consensus Statement On Psoriasis Therapies

☐ Psoriasis is covering greater than 10% body surface area
☐ Psoriasis is on palms, soles, head & neck, or genitals
☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐ Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment, or interpersonal relationships

Scoring Tool ☐ BSI ☐ EASI ☐ SCORAD ☐ POEM ☐ ISGA % or SCORE ___
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No

☐ Home ☐ MD Office ☐ Other: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Refills:
☐ Humira® Citrate Free	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SUBQ on Day 1, 40 mg on Day 8, then 40 mg every other week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every other week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SUBQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** Weight Required: _____ ☐ **INITIAL:** Inject 160 mg SUBQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every week (Quantity: 4) ****Intended for weight > 60 kg/132 lbs***** _____	
☐ Humira®	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SUBQ on Day 1, 40 mg on Day 8, then 40 mg every other week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every other week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SUBQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** Weight Required: _____ ☐ **INITIAL:** Inject 160 mg SUBQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every week (Quantity: 4) ****Intended for weight > 60 kg/132 lbs***** _____	
		ADOLESCENT: Weight Required: _____ ☐ **INITIAL:** Inject 160 mg SUBQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SUBQ every week (Quantity: 4) ****Intended for weight > 60 kg/132 lbs***** _____	

Prescriber Signature: _____ **Date:** _____