InfuCare Rx®

Neurology Injectable Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

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

☐ 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 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:** _____