InfuCare Rx®

Rheumatology IV Infusion Enrollment Form

Fax Referral To: 877-277-9155
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	PRESCRIBER INFORMATION
Patient Name: ____________	Prescriber Name: ____________
Address: ____________	Address: ____________
City, State, Zip: ____________	City, State, Zip: ____________
Home Phone: ____________	Phone: ____________
Cell Phone: ____________	Fax: ____________
Date of Birth: ____________ Gender: ____________	DEA #: ____________ NPI #: ____________
Emergency Contact: ____________ Phone: ____________	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:				

Premedications & 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 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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