InfuCare Rx®

Gastroenterology 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

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

☐ K50.00 Crohn's Disease
☐ K51.90 Ulcerative Colitis
☐ Other: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____
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:	Refills:
☐ Cimzia®	☐ 200 mg prefilled syringe ☐ 200 mg vial	☐ **Initial:** Inject 400 mg (two 200 mg injections) SUBQ on day 0, 14, and 28 (Quantity: 6) ☐ **Maintenance:** Inject 400 mg (two 200 mg injections) SUBQ every 4 weeks (Quantity: 2)	
☐ Entyvio®	☐ 300 mg vial	☐ **Initial:** Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) ☐ **Maintenance:** Infuse 300 mg IV over 30 minutes every _____ weeks (Quantity: 1)	
☐ Humira® ☐ Humira® Citrate Free	☐ Crohn's/UC Starter Package ☐ 40 mg Pen ☐ 40 mg prefilled syringe	☐ **Initial:** Inject 160 mg SUBQ on day 1, then 80 mg day 15, then maint. dose (1 pkg) ☐ **Maintenance:** Inject 40 mg SUBQ every other week (Quantity: 2)	
☐ Avsola® ☐ 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)	
☐ Simponi®	☐ 100 mg SmartJect® Pen ☐ 100 mg prefilled syringe	☐ **Initial:** Inject 200 mg SUBQ on day 0, then 100 mg on day 14 (Quantity: 3) ☐ **Maintenance:** Inject 100 mg SUBQ every 4 weeks (Quantity: 1)	
☐ Skyrizi IV®	☐ 600mg/10mL vial	☐ **Initial:** 600mg administered by IV over at least one hour at week 0, week 4, and week 8 (Quantity: 3) **Induction Dosing Only	
☐ Stelara®	☐ 130 mg (26mL vials) ☐ 90 mg (2x 45 mg vials)	☐ **Initial:** Weight based dosing, infuse IV up to 55 kg = 260 mg (2 vials), > 55 kg to 85 kg = 390 mg (3 vials), > 85 kg = 520 mg (4 vials) ☐ **Maintenance:** Inject 90 mg SUBQ 8 weeks after initial dose, then every 8 weeks thereafter	
☐ Other:			

Premedications & Other Medications:
- Infusion supplies as per protocol
- Anaphylaxis Kit as per protocol

☐ Acetaminophen: _____ mg PO prior to infusion
☐ Diphenhydramine: _____ mg ☐ PO ☐ IV
☐ 250ml 0.9% NaCl for hydration
☐ 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:** _____