InfuCare Rx®

Immuno-Oncology Enrollment Form

Fax Referral To: 877-277-9155
Phone: 877-828-3940
referrals@infucarerx.com

✂ 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

☐ ICD-10 Code: _____
☐ Diagnosis: _____
Prior Medication: _____
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:	Quantity:	Refills:
☐ Keytruda®	☐ 100mg/4mL vial	☐ Infuse 200mg IV over at least 30 minutes every 3 weeks ☐ Infuse 400mg IV over at least 30 minutes every 6 weeks		
☐ Imfinzi®	☐ 120mg/2.4mL vial ☐ 500mg/10mL vial	☐ Patients >/= 30kg: Infuse 10mg/kg IV every 2 weeks ☐ Patients >/=30kg: Infuse 1500mg IV every 4 weeks ☐ Patients < 30kg: Infuse 10mg/kg IV every 2 weeks ☐ Patients < 30kg: Infuse 20mg/kg IV every 4 weeks		
☐ Opdivo®	☐ 40mg/4mL vial ☐ 100mg/10mL vial ☐ 120mg/12mL vial ☐ 240mg/24mL vial	☐ Infuse 240mg IV every 2 weeks ☐ Infuse 360mg IV every 3 weeks ☐ Infuse 480mg IV every 4 weeks ☐ Other: _____		
☐ Opdivo Qvantig®	☐ 600mg/10,000 units vial	☐ Inject 600mg/10,000 units SUBQ every 2 weeks ☐ Inject 600mg/10,000 units SUBQ every 4 weeks ☐ Inject 900mg/15,000 units SUBQ every 3 weeks		
☐ Yervoy®	☐ 50mg/10mL vial ☐ 200mg/40mL vial	☐ 3 mg/kg IV every 3 weeks for 4 doses ☐ 3 mg/kg IV every 3 weeks for 4 doses, followed by 3 mg/kg IV every 12 weeks for up to 4 additional doses.		
☐ Opdivo® + Yervoy®		☐ Opdivo 3mg/kg IV followed by Yervoy 1mg/kg IV on the same day, every 3 weeks for 4 doses ☐ Opdivo 1mg/kg IV followed by Yervoy 3mg/kg IV on the same day, every 3 weeks for 4 doses ☐ Opdivo 240mg IV followed by Yervoy 1mg/kg IV on the same day every 3 weeks for 4 doses ☐ Opdivo 360mg IV every 3 weeks and Yervoy 1mg/kg IV every 6 weeks ☐ Opdivo 3mg/kg IV every 2 weeks and Yervoy 1mg/kg IV every 6 weeks		
☐ Other:				

Lab Orders:
☐ NA ☐ Other: _____
► Infusion supplies as per protocol

Premedications:
☐ Acetaminophen 650mg PO 30 minutes before infusion, may repeat every 4 to 6 hours as needed
☐ Diphenhydramine 25mg PO 30 minutes before infusion, may repeat every 4 to 6 hours as needed

Anaphylaxis Orders:
☐ Epinephrine 0.3mg IM x 1 as needed for first dose administration. May repeat in 15 minutes and call 911
☐ Diphenhydramine 50mg IV push over 2 minutes x 1 as needed for first dose administration for uticaria, pruritus or shortness of breath

SPIV Flush Protocol:
☐ 10mL 0.9% NaCl before and after each use and as needed

CVAD or Midline Flush Protocol:
☐ 10mL 0.9% NaCl before and after each use followed by 5mL Heparin (10 units/mL)
☐ 20mL 0.9% NaCl followed by 5mL heparin 10 units/mL) after each lab draw

Port Flush Protocol:
☐ 10mL 0.9% NaCl before and after each use followed by 5mL heparin (100 units/mL)
☐ 20mL 0.9% NaCl followed by 5mL heparin (100 units/mL) after each lab draw

► Skilled nursing orders: Nurse to establish IV access and administer ordered medication(s) via patient's access device. Nurse to manage and provide support for IV access device as needed for the provided medication(s).

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:** _____

Revised 15 Jun 2025