InfuCare Rx®

Autoimmune Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940
referrals@infucarerx.com
www.infucarerx.health

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:

DIAGNOSIS

☐ D69.3 Immune thrombocytopenic purpura (ITP)
☐ G04.81 Other encephalitis and encephalomyelitis
☐ L10.9 Pemphigus, unspecified
☐ L12.8 Other pemphigoid
☐ M30.3 Mucocutaneous lymph node syndrome (Kawasaki disease)
☐ M32.0 Systemic lupus erythematosus (SLE)
☐ M33.20 Polymyositis, organ involvment unspecified
☐ M33.90 Dermatomyositis, unspecified, organ involvement unspecified
☐ Other: _____

☐ Patient demographics, including insurance information
☐ Labs – Antibody testing results, most recent BUN/SCr and IgA level
☐ H&P
☐ Medications/therapies tried and failed
☐ Baseline assessment, including detailed patient symptoms
☐ Please attach original prescription orders

PATIENT EVALUATION

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: _____
Therapy Start Date: _____ Therapy End Date: _____

Nursing Coordination:
☐ 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

PRESCRIPTION INFORMATION

Immune Globulin Prescription:

Loading Dose: IVIG _____ gm per kg given over _____ day(s) OR _____ gm daily for _____ day(s)

Maintenance: IVIG _____ gm per kg given over _____ day(s) OR _____ gm daily for _____ day(s)

☐ Repeat course every _____ week(s) x _____ course(s)
☐ Refill x _____ (length of time)

☐ OK to round to the nearest vial size
☐ +/- 4 days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 5mL
☐ NaCl 0.9% 10mL
☐ Heparin 10 units per mL
☐ Heparin 100 units per mL
☐ 250mL 0.9% NaCl for hydration
☐ Other: _____

Premedications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis kit orders as per protocol
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

Prescriber Signature: _____ **Date:** _____

Revised 09 Jan 2026