Immuno-Oncology Enrollment Form
Intravenous (IV) Medications

InfuCare Rx®
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Phone: 877-828-3940
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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:

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®	☐ 100 mg/4 mL vial	☐ Infuse 200 mg IV every 3 weeks ☐ Infuse 400 mg IV every 6 weeks		
☐ Imfinzi®	☐ 120 mg/ 2.4mL vial ☐ 500 mg/ 10mL vial	☐ Patients >/= 30 kg: Infuse 10mg/kg IV every 2 weeks ☐ Patients >/=30 kg: Infuse 1500mg IV every 4 weeks ☐ Patients < 30 kg: Infuse 10mg/kg IV every 2 weeks ☐ Patients < 30 kg: Infuse 20mg/kg IV every 4 weeks		
☐ Darzalex®	☐ 100 mg/ 5mL vial ☐ 400 mg/ 20mL vial	☐ Infuse 16 mg/kg of actual body weight IV every week for total of 8 doses, then every 2 weeks from weeks 9 to 24 for a total of 8 doses, then every 4 weeks from week 25 onwards		
☐ Jemperli®	☐ 500 mg/10 mL vial	☐ Infuse 500 mg IV every 3 weeks for 4 cycles, then 1000 mg IV every 6 weeks thereafter		
☐ Libtayo®	☐ 350 mg/7 mL vial	☐ Infuse 350 mg IV every 3weeks ☐ Infuse 350 mg IV every 3 weeks for 12 weeks, then 700 mg IV every 6 weeks		
☐ Loqtorzi®	☐ 240 mg/6 mL vial	☐ 3 mg/kg IV every 2 weeks ☐ 240 mg IV every 3 weeks		
☐ Opdivo®	☐ 40 mg/4 mL vial ☐ 100 mg/10 mL vial ☐ 120 mg/12 mL vial ☐ 240 mg/24 mL vial	☐ Infuse 240 mg IV every 2 weeks ☐ Infuse 360 mg IV every 3 weeks ☐ Infuse 480 mg IV every 4 weeks		
☐ Yervoy®	☐ 50 mg/10 mL SDV ☐ 200 mg/40 mL SDV	☐ 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 3 mg/kg IV followed by Yervoy 1mg/kg IV on the same day, every 3 weeks for 4 doses ☐ Opdivo 1 mg/kg IV followed by Yervoy 3mg/kg IV on the same day, every 3 weeks for 4 doses ☐ Opdivo 240 mg IV followed by Yervoy 1mg/kg IV on the same day every 3 weeks for 4 doses ☐ Opdivo 360 mg IV every 3 weeks and Yervoy 1mg/kg IV every 6 weeks ☐ Opdivo 3 mg/kg IV every 2 weeks and Yervoy 1mg/kg IV every 6 weeks		
☐ Rybrevant®	☐ 350 mg/7 mL vial	☐ Patients < 80 kg: Infuse 1050 mg IV every week for a total of 5 doses (For Week 1- split infusion on Day 1 and Day 2), then week 6 – no dose, then every 2 weeks starting at week 7 onwards ☐ Patients >/= 80 kg: Infuse 1400 mg IV every week for a total of 5 doses (For Week 1- split infusion on Day 1 and Day 2), then week 6 – no dose, then every 2 weeks starting at week 7 onwards		
☐ Tecentriq®	☐ 840 mg/14 mL vial ☐ 1200 mg/20 mL vial	☐ Infuse 840 mg IV every 2 weeks ☐ Infuse 1200 mg IV every 3 weeks ☐ Infuse 1680 mg IV every 4 weeks		
☐ Zynyz®	☐ 500 mg/20 mL vial	☐ Infuse 375 mg IV every 3 weeks ☐ Infuse 500 mg IV every 4 weeks		

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

Premedications & Other Medications

☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Other: _____
☐ Acetaminophen _____ mg PO prior to infusion
☐ Diphenhydramine _____ mg PO

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 30 July 2026