Immuno-Oncology Enrollment Form
Subcutaneous (SUBQ) Medications

InfuCare Rx®
Fax Referral To: 877-277-9155
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:

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:
☐ Darzalex Faspro®	☐ 1800 mg/30000 units vial	☐ Inject 1800 mg/30000 units SUBQ 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 ☐ Other: _____		
☐ Keytruda Qlex®	☐ 395 mg/4800 units vial ☐ 790 mg/9600 units vial	☐ Inject 395 mg/4800 units SUBQ every 3 weeks ☐ Inject 790 mg/9600 units SUBQ every 6 weeks		
☐ Opdivo Qvantig®	☐ 300 mg/5000 units vial ☐ 600 mg/10000 units vial	☐ Inject 600 mg/10000 units SUBQ every 2 weeks ☐ Inject 900 mg/15000 units SUBQ every 3 weeks ☐ Inject 1200 mg/20000 units SUBQ every 4 weeks		
☐ Rybrevant Faspro®	☐ 1600 mg/20000 units vial ☐ 2240 mg/28000 units vial ☐ 2400 mg/30000 units vial ☐ 3520 mg/44000 units vial	☐ Patient < 80 kg: Inject 1600 mg/20000 units SUBQ every week for a total of 4 doses, then every 2 weeks starting at week 5 onwards ☐ Patient >/= 80 kg: Inject 2240 mg/28000 units SUBQ every week for a total of 4 doses, then every 2 weeks starting at week 5 onwards ☐ Patient < 80 kg: Inject 1600 mg/20000 units SUBQ every week for a total of 4 doses, then inject 3520 mg/44000 units SUBQ every 4 weeks starting at week 5 onwards ☐ Patient >/= 80 kg: Inject 2240 mg/28000 units SUBQ every week for a total of 4 doses, then inject 4640 mg/58000 units SUBQ every 4 weeks starting at week 5 onwards ☐ Other: _____		
☐ Tecentriq Hybreza®	☐ 1875 mg/30000 units vial	☐ Inject 1875 mg/30000 units SUBQ every 3 weeks		
☐ Other:	☐ _____	☐ _____		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Premedications & Other Medications

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

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 17 July 2026