InfuCare Rx®

Rheumatology IV Infusion Enrollment Form

Fax Referral To: 877-277-3278
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

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.9 Systemic Lupus Erythematosus
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis
☐ L40.0 Moderate to Severe Plaque Psoriasis
☐ L40.50 Psoriatic Arthritis
☐ L40.59 Psoriasis with Arthropathy
☐ Other: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____
HBV: ☐ Positive ☐ Negative ☐ NA ☐ Date Read: _____
____CBC ____CMP
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
☐ 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

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

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Actemra®	☐ 80mg/4mL ☐ 200mg/10mL ☐ 400mg/20mL	☐ Induction Dose: Infuse 4 mg/kg IV every 4 weeks ☐ Maitenence Dose: Infuse up to 8 mg/kg IV every 4 weeks based on clinical response ☐ Other: _____		
☐ Benlysta®	☐ 120mg vial ☐ 400mg vial	☐ Induction Dose: 10mg/kg. Dose = _____ mg at 2 week intervals for the first 3 doses and at 4-week intervals thereafter. Infuse IV over 1 hour ☐ Maitenence Dose: 10mg/kg. Dose = _____ mg every 4 weeks. Infuse IV over 1 hour		
☐ Cosentyx IV®	☐ 125mg/5mL SDV	☐ Induction Dose: Infuse 6mg/kg IV over at least 30 minutes at week 0 ☐ Maitenence Dose: Infuse 1.75mg/kg IV over at least 30 minutes at week 4 and every 4 weeks thereafter (maximum maintenance dose 300mg per infusion)		
☐ Krystexxa®		☐ Please refer to Krystexxa® enrollment form.		
☐ Orencia®	☐ 250mg vial	☐ Infuse IV _____ mg at weeks 0, 2 and 4, then every 4 weeks thereafter ☐ Other: _____		
☐ Inflectra® ☐ Remicade® ☐ Renflexis®	☐ 100mg vial	☐ Initial Dose:Infuse IV _____ mg/kg (Dose _____mg) at 0, 2, and 6 weeks (Quantity: _____) ☐ Maitenence Dose: Infuse IV _____ mg/kg (Dose _____ mg) every _____ weeks (Quantity: _____) ☐ Other: _____ ☐ Pharmacist will round to the nearest 100 ☐ Give exact dose (do NOT round)		
☐ Rituxan®	☐ 100mg/10mL SDV ☐ 500mg/50mL SDV	☐ Infuse IV two doses of 1000 mg separated by 2 weeks ☐ Other: _____		
☐ Saphnelo®	☐ 300mg/2mL SDV	☐ Infuse 300mg IV over at least 30 minutes every 4 weeks		
☐ Simponi Aria®	☐ 50mg/4mL SDV	☐ Infuse 2mg/kg IV over 30 minutes at weeks 0 and 4, then every 8 weeks thereafter ☐ Other: _____		
☐ 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:** _____

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