InfuCare Rx®

Rheumatology Subcutaneous Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881
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
☐ M32.10 Systemic Lupus Erythematosus
☐ L40.50 Psoriatic Arthritis
☐ Other: _____
Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

TB/PPD Test: ☐ Positive ☐ Negative ☐ Date Read: _____
____CBC ____CMP Forteo T-score: _____ Type: _____ Date: _____ Site: _____
Fractured: _____ Date: _____
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:
☐ Actemra®	☐ 162mg PFS	☐ Inject 162mg every other week (under 100kg) ☐ Inject 162mg every week (over 100kg)	1 month supply	
☐ Benlysta®	☐ 200mg Autoinjector ☐ 200mg PFS	☐ Inject 200mg SUBQ ONCE a week	4 week supply	
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SUBQ at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	1 month supply	
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS	☐ Load: Inject ☐ 300mg or ☐ 150mg SUBQ week 0,1,2,3,4 ☐ Maintenance: Inject ☐ 300mg or ☐ 150mg SUBQ every 4 weeks	5 week supply 4 week supply	
☐ Enbrel®	☐ 50mg Sureclick ☐ 25mg Vials ☐ 50mg PFS ☐ 25mg PFS ☐ Mini™ with Autotouch™	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg once weekly ☐ Inject 25mg twice weekly	1 month supply	
☐ Forteo®	☐ 750µg per 3mL pen and supplies	☐ Inject 20 µg SUBQ once daily	1 month supply	
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SUBQ once a week ☐ Inject 40mg SUBQ every other week	1 month supply	
☐ Kevzara®	☐ 150mg PFS ☐ 200mg PFS	☐ Inject one PFS SUBQ every 2 weeks	1 month supply	
☐ Methotrexate	☐ 2.5mg tab ☐ 25mg per mL vial	☐ Take _____mg by mouth once weekly ☐ Inject _____mg SUBQ once weekly	1 month supply	
☐ Orencia®	☐ 125mg PFS ☐ 250mg Vial	☐ Inject 125mg once weekly ☐ Inject _____mg once monthly	1 month supply	
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth twice daily ☐ Take as per package instructions	1 month supply	
☐ Otrexup™	☐ _____mg per 0.4mL	☐ Inject _____mg once weekly	1 month supply	
☐ Rasuvo®	☐ _____mg	☐ Inject _____mg once weekly	1 month supply	
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SUBQ once monthly	1 month supply	
☐ Stelara®	☐ 45mg vials ☐ 90mg (2 x 45mg vials)	☐ Inject 45mg SUBQ at week 0 and week 4, then inject 45mg SUBQ every 12 weeks ☐ Inject 90mg SUBQ at week 0 and week 4, then inject 90mg SUBQ every 12 weeks	1 month supply	
☐ Xeljanz®	☐ 5mg tablet ☐ XR 11mg tablet	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth once daily	1 month supply	
☐ 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:** _____

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