

Phone : 844-800-5377

Fax : 214-782-9155

**RHEUMATOLOGY INFUSION RX ENROLLMENT FORM**

Referral Date: \_\_\_\_\_ Ship to:  Home  Office  Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

**INSURANCE INFORMATION** Please fax copy of prescription and insurance cards with this form if available (front and back)

Prior Authorization Reference Number: \_\_\_\_\_

**DIAGNOSIS**

M06.9 Rheumatoid Arthritis  
 M08.0 Juvenile Rheumatoid Arthritis  
 M45.9 Ankylosing Spondylitis  
 L40.59 Psoriatic Arthritis  
 Other: \_\_\_\_\_  
 Date of Diagnosis: \_\_\_\_\_  
 Other Conditions: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**CLINICAL INFORMATION**

Patient Weight: \_\_\_\_\_  kg  lbs  
 Allergies: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 CrCl: \_\_\_\_\_ Hepatitis B ruled out:  Yes  No  
 TB Test performed:  Yes  No Results: \_\_\_\_\_  
**Therapy**  New  Reauthorization  Restart  
**Prior Therapy:** \_\_\_\_\_  
 Tx Response and Dates: \_\_\_\_\_  
 Pharmacy to coordinate home health nursing visit and/or nursing training  
 Patient already trained on subcutaneous infusion

**PRESCRIPTION INFORMATION** RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

Medication	Strength	Dose and Directions	Quantity	Refills
<input type="checkbox"/> Actemra®	<input type="checkbox"/> 80mg/4mL vial <input type="checkbox"/> 200mg/10mL vial <input type="checkbox"/> 400mg/10mL vial	Patient Weight: _____ <input type="checkbox"/> Infuse 4 mg/kg IV every 4 weeks over one hour. <input type="checkbox"/> Infuse 8mg/kg IV every 4 weeks over one hour.		
<input type="checkbox"/> Orencia®	<input type="checkbox"/> 250mg vial	<input type="checkbox"/> Infuse _____ mg/kg at weeks 0, 2 and 4, then every 4 weeks thereafter.		
<input type="checkbox"/> Remicade® <input type="checkbox"/> Inflectra® <input type="checkbox"/> Renflexis® <input type="checkbox"/> Avsola®	<input type="checkbox"/> 100mg vial	<input type="checkbox"/> Loading Dose: Infuse _____ mg/kg IV at week 0, week 2, week 6 then <input type="checkbox"/> Maintenance Dose: Infuse _____ mg/kg once every 8 weeks. <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Rituxan® <input type="checkbox"/> Truxima® <input type="checkbox"/> Ruxience® <input type="checkbox"/> Riabni®	<input type="checkbox"/> 500mg vial	<input type="checkbox"/> Loading Dose: Inject 100mg SQ at Week 0 and Week 4. <input type="checkbox"/> Maintenance Dose: Inject 80mg SQ once every 4 weeks (starting at Week 4).		
<input type="checkbox"/> Simponi® Aria	<input type="checkbox"/> 50mg/4mL vial	<input type="checkbox"/> Infuse 2mg/kg IV over 30 minutes at weeks 0 & 4, then every 8 weeks.		
<input type="checkbox"/> Other: _____				



Phone : 844-800-5377

Fax : 214-782-9155

**RHEUMATOLOGY ORAL/SQ RX ENROLLMENT FORM**

Referral Date: \_\_\_\_\_ Ship to:  Home  Office  Other \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

**CLINICAL INFORMATION**

Patient Weight: \_\_\_\_\_  kg  lbs  
 Allergies: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 CrCl: \_\_\_\_\_ Hepatitis B ruled out:  Yes  No  
 TB Test performed:  Yes  No Results: \_\_\_\_\_

**Therapy**  New  Reauthorization  Restart  
**Prior Therapy:** \_\_\_\_\_  
 Tx Response and Dates: \_\_\_\_\_  
 Pharmacy to coordinate home health nursing visit and/or nursing training  
 Patient already trained on subcutaneous infusion

**REQUIRED FOR HOME INFUSION RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.**

**IV Access & Infusion Method**  
 To be administered PERIPHERALLY, unless otherwise indicated.  PORT  PICC  
 To be infused via gravity infusion or per CarePartners RPh discretion, unless otherwise indicated.  MD prefers Infusion Pump

**Flush Protocol for IVIG drug admin days only**  
 • 0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH.  
 • Heparin 10 units/mL: 5mL IV (peripheral) PRN for final flush. \*For multi-day infusions  
 • Heparin 100 units/mL: 5mL IV (central) PRN for final flush.  
 \* For multi-day infusions, peripheral IV to be obtained, maintained, and discontinued for the duration of the infusion cycle per RN discretion in accordance with INS guidelines.

<b>Pre and Post Medications</b> Please strikethrough if not required	<b>To be given BY MOUTH 30 minutes prior to infusion. May repeat every 4-6 hours as needed.</b>				<b>*For subcutaneous patients only* if requested by patient/nurse. Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection site(s) at least 1 hour prior to needle insertion.</b>	
		<b>Adult</b>	<b>6-12 years old</b>	<b>2-5 years old</b>		<b>&lt;2 years old</b>
	<b>Diphenhydramine 25mg-50mg</b>	max 100mg/day	12.5mg - 25 mg PO	6.25mg - 12.5mg PO		1mg/kg up to max 6.25mg PO
	<b>Acetaminophen 325mg-650mg</b>	max 3000mg/day	10-15mg/kg PO			

**Anaphylaxis Protocol**  
 To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.  
 • Epinephrine 0.3mg ( ≥30kg/66lbs)  
 • Epinephrine 0.15mg (15kg to <30kg /33lbs to <66lbs)  
 • For IVIG only: Epinephrine ampule 0.1mg (7.5kg to <15kg /16.5lbs to <33lbs)

**Hydration**  
 Please select only if needed for IVIG  
 0.9% NaCl \_\_\_\_\_ mL infused over \_\_\_\_\_ minutes  
 D5W \_\_\_\_\_ mL infused over \_\_\_\_\_ minutes  
 Nurse to determine hydration rate if rate not provided above.  
**To be infused pre-infusion, unless otherwise indicated.**  
 Concurrent with Infusion  
 Other \_\_\_\_\_

**Diphenhydramine**  
 Please select only if needed for IVIG  
**To be given via slow IV push PRN for moderate – severe reaction.**  
 25-50mg \*For IV Adult Patients only\*  1mg/kg/dose (Max dose 50mg) \*For IV Pediatric Patients Only\*

**Quantity and Refills**  
 Dispense 1-month supply with 1-year refill unless indicated below.  
 Dispense 3-month supply with 1-year refill  Other \_\_\_\_\_

**Additional Orders**

**PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

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.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible <b>Prescriber Signature</b> _____ <b>Date</b> _____	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute <b>Prescriber Signature</b> _____ <b>Date</b> _____
--	---

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" \_\_\_\_\_ NY & Iowa providers, please submit electronic prescription.

*IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to EPSRx or any of its subsidiaries using the contact information provided on this coversheet. This referral form is intended to assist with the processing of the patient's prescription and can be used at any pharmacy of the patient's choosing. It is not limited to the pharmacy listed on the form, nor does it imply that the patient is required to fill their prescription at a specific location. Patients maintain the right to select the pharmacy that best meets their needs. Please refer to TSBP Rule 281.7(15) for further guidance.*