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
☐ Actemra®	☐ 80mg/4mL vial ☐ 200mg/10mL vial ☐ 400mg/10mL vial	Patient Weight: ____ ☐ Infuse 4 mg/kg IV every 4 weeks over one hour. ☐ Infuse 8mg/kg IV every 4 weeks over one hour.		
☐ Orencia®	☐ 250mg vial	☐ Infuse ____ mg/kg at weeks 0, 2 and 4, then every 4 weeks thereafter.		
☐ Remicade® ☐ Inflectra® ☐ Renflexis® ☐ Avsola®	☐ 100mg vial	☐ Loading Dose: Infuse ____ mg/kg IV at week 0, week 2, week 6 then ☐ Maintenance Dose: Infuse ____mg/kg once every 8 weeks. ☐ Other: ____		
☐ Rituxan® ☐ Truxima® ☐ Ruxience® ☐ Riabni®	☐ 500mg vial	☐ Loading Dose: Inject 100mg SQ at Week 0 and Week 4. ☐ Maintenance Dose: Inject 80mg SQ once every 4 weeks (starting at Week 4).		
☐ Simponi® Aria	☐ 50mg/4mL vial	☐ Infuse 2mg/kg IV over 30 minutes at weeks 0 & 4, then every 8 weeks.		
☐ Other: ____				

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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.

Pre and Post Medications

Please strikethrough if not required

To be given BY MOUTH 30 minutes prior to infusion. May repeat every 4-6 hours as needed.

	Adult	6-12 years old	2-5 years old	<2 years old
Diphenhydramine 25mg-50mg	max 100mg/day	12.5mg - 25 mg PO	6.25mg - 12.5mg PO	1mg/kg up to max 6.25mg PO
Acetaminophen 325mg-650mg	max 3000mg/day	10-15mg/kg PO		

***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.

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.

☐ May Substitute/Product Selection Permitted/Substitution Permissible		☐ Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute	
Prescriber Signature	**Date**	**Prescriber Signature**	**Date**

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

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