CarePartners Specialty Infusion

Autoimmune IV Infusion Enrollment Form

Fax Referral To: 866-832-7180
Phone: 866-852-0202

To better serve your patient and facilitate insurance authorization, please attach the following:

- **Patient demographics, H&P, and labs**
- **The front and back of insurance & prescription drug card**

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: _____

CLINICAL INFORMATION

DIAGNOSIS:

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

Requested Therapy Start Date: _____
Prior Medication Failed: _____

PATIENT EVALUATION:

TB/PPD Test: ☐ Positive ☐ Negative Date Read: _____
Hepatitis B virus screening result: ☐ Positive ☐ Negative Date Read: _____
Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____ ☐ NKDA
Pharmacy to coordinate home health nursing visit: ☐ Yes ☐ No
If home health nursing coordination not necessary, please indicate reason:
- ☐ MD office or infusion center to administer to patient
- ☐ Home health nursing already coordinated

Length of Failed Treatment: _____
Reason for Discontinuation: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE ** to be calculated based on actual body weight**	DIRECTIONS	QUANTITY DISPENSE	REFILLS
☐ Actemra®	☐ Dose: _____ mg ☐ 4 mg/kg ☐ 8 mg/kg	☐ Induction dose: Infuse ____ mg IV every 4 weeks	☐ 1 month ☐ 3 months	_____
		☐ Maintenance dose: : Infuse ____ mg IV every ____ weeks	☐ 1 month ☐ 3 months	_____
☐ Benlysta®	☐ Dose: _____ mg ☐ 10 mg/kg	☐ Induction dose: Infuse ____ mg IV at weeks 0, 2 and 4	Dispense week 0, 2, 4	NONE
		☐ Maintenance dose: : Infuse ____ mg IV every ____ weeks	☐ 1 cycle ☐ 1 month ☐ 3 months	_____
☐ Orencia®	☐ 500mg ☐ 750mg ☐ 1000mg ☐ Other: _____	☐ Induction dose: Infuse ____ mg IV at weeks 0, 2 and 4	Dispense week 0, 2, 4	NONE
		☐ Maintenance dose: : Infuse ____ mg IV every 4 weeks	☐ 1 month ☐ 3 months	_____
☐ Inflectra® ☐ Remicade® ☐ Renflexis®	☐ Dose: _____ mg ☐ 3 mg/kg ☐ 5 mg/kg ☐ 10 mg/kg	☐ Induction dose: Infuse ____ mg IV at weeks 0, 2 and 6	Dispense week 0, 2, 6	NONE
		☐ Maintenance dose: : Infuse ____ mg IV every ____ weeks	Qty: _____ vials *1 vial = 100mg*	_____
***Pharmacist to round to the nearest 100mg, unless otherwise indicated. ☐ Give exact dose (do NOT round)				
☐ Simponi Aria®	☐ Dose: _____ mg ☐ 2 mg/kg	☐ Induction dose: Infuse ____ mg at weeks 0 and 4	Dispense week 0 and 4	NONE
		☐ Maintenance dose: : Infuse ____ mg every ____ weeks	☐ 1 cycle ☐ 1 month ☐ 3 months	_____
☐ Other:	_____	_____	_____	_____

REQUIRED for HOME INFUSION

To be infused via peripheral IV access, unless otherwise indicated. ☐ PORT ☐ PICC ***Flushes to be provided per CarePartners protocol on page 2*

DELIVERY METHOD: To be infused via gravity infusion, unless otherwise indicated ☐ MD prefers Infusion Pump

HYDRATION: Please select only if needed
- ☐ 0.9% NaCl _____ ml infused over _____ minutes
- ☐ D5W _____ ml infused over _____ minutes

*To be infused pre-infusion, unless otherwise specified below.
- ☐ Post-Infusion
- ☐ Concurrently with infusion

☐ **MD agrees that the order is to be infused per CarePartners Infusion protocols on page 2.**

- OR -

☐ **MD has made adjustments to CarePartners Infusion protocols on page 2, and agrees to the remaining unadjusted protocols.**

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:** _____

☐ Dispense as Written
☐ Product Substitution Permitted

CarePartners Specialty Infusion Protocols

FLUSH PROTOCOL: to be provided for IV drug administration days only.

- 0.9% NaCl: 1-5ml intravenous (peripheral line) or 10ml intravenous (central line) before/after infusion, or as needed for line patency/SASH.
- Heparin 10 units/ml: 5ml intravenous (peripheral line) as needed for final flush.
- Heparin 100 units/ml: 5ml intravenous (central line) as needed for final flush.

PREMEDICATIONS: to be given 30 minutes prior to infusion *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

Diphenhydramine 25mg-50mg by mouth
For pediatric diphenhydramine patients:

- <2 years old: 1mg/kg up to max 6.25mg po
- 2-5 years old: 6.25mg-12.5mg po
- 6-12 years old: 12.5mg-25mg po

Acetaminophen 325mg-650mg by mouth
For acetaminophen patient's weighing < 60kg:
10-15mg/kg po

MEDICATIONS to be used as needed/requested by patient/nurse *(PLEASE STRIKE THROUGH IF NOT REQUIRED)*

- Diphenhydramine: May repeat premedication dose every 4-6 hours as needed. Adult max: 100mg/day.
- Acetaminophen: May repeat premedication dose every 4-6 hours as needed. Adult max: 3000mg/day.
- Lidocaine 2.5%/Prilocaine 2.5% topical (may dispense Lidocaine 4%) to injection sites at least 1 hour prior to needle insertion.

ANAPHYLAXIS PROTOCOL: Pharmacy to provide the following as needed for anaphylactic reaction:

- Diphenhydramine 25mg- 50mg PO as needed for mild-moderate reaction. qty: 2
- Diphenhydramine 25mg- 50mg via slow IV push as needed for moderate-severe reaction. qty: one 50mg/ml vial
- Sodium Chloride 0.9% 500ml bag IV PRN for anaphylactic reaction. qty: 500ml
- Epinephrine 0.3mg (patient's weighing ≥ 30kg/66lbs)
- Epinephrine 0.15mg (patient's weighing between 15-30kg/33-66lbs)

Administer intramuscularly PRN severe allergic reaction.
Call 911. May repeat x 1.

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

Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

ADDITIONAL ORDERS: