LUX INFUSION

# Treatment Enrollment Form

Toll Free Phone: 1-866-665-3244 | Toll Free Fax:1-844-461-3244 | Email: infusions@luxinfusion.com

## Patient Information

Patient Name: _____ SSN#: _____ Gender: ☐ Male ☐ Female

DOB: _____ Language Preference: ☐ English ☐ Spanish ☐ Other _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ E-mail Address: _____

Emergency/guardian Contact: _____ Emergency/guardian Phone: _____

## Insurance Information – Please attach front and back of patient's insurance cards

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Name of Insured: _____ Relationship to Patient: _____

Prescription Card: ☐ Yes ☐ No _____ ID#: _____

PCP Referral Required: ☐ Yes ☐ No PCP Name: _____

## Prescriber Information

Prescriber's Name: _____ Hospital/Group: _____

Street Address: _____ Office Phone: _____

City, State, Zip: _____ Office Fax: _____

E-mail Address: _____ Office Contact Person: _____

NPI#: _____ Tax ID#: _____ State License#: _____

## Prior Authorization Information – For us to complete PAs for you, please send the following:

- ○ Patient demographic page
- ○ Patient SSN
- ○ Most recent H&P
- ○ Most recent labs
- ○ Copy of any/all insurance cards on file, both medical and pharmacy

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## Patient Information

Patient Name: _____ DOB: _____

# Remicade

Infusion Order Form

## Clinical Information

Primary ICD-10 Code: _____ Weight: _____ (kg ◯ / lbs ◯) Height: _____ (cm ◯ / in ◯)

Patient previously treated for this condition: ☐ Yes ☐ No Patient currently on treatment: ☐ Yes ☐ No

Known Allergies: _____

All ICD-10 codes for any/all related diagnosis (if not listed in H&P): _____

## Pre-medication Information

- ✓ **Acetaminophen 325mg, can be repeated x1, not to exceed 650mg, PRN**
- ✓ **Diphenhydramine 25mg PO or IV, PRN**
- ✓ **Histamine H2 receptor antagonist PO or IV, PRN**
- ✓ **Methylprednisolone 125mg IV, PRN**
- ✓ **Ondansetron 4mg IV, PRN**
- ☐ _____

## Prescriber must indicate the following requirements have been met (must provide documentation)

☐ **Latent TB test negative – OR – if positive proof of TB treatment prior to starting therapy (see package insert)**

☐ **HBV screening negative**

**If any the above are not checked, attach treatment/consultation notes clearing patient for infusion therapy**

## Medication Information

| Medication | Note: PFS is abbreviation for Prefilled Syringes | Directions/Frequency | IV Access Type: ☐ Peripheral ☐ PICC ☐ Port |
|---|---|---|---|
| **Remicade (infliximab)**<br>☐ _____mg/kg (weight-based) at weeks 0, 2, and 6, then every 8 weeks<br>☐ _____mg (flat-dose) at weeks 0, 2, and 6, then every 8 weeks<br>☐ _____mg/kg (weight-based) every ____ weeks<br>☐ _____mg (flat-dose) every ____ weeks<br><br>PI recommends: For patients with RA, should be given in combination with methotrexate. | | ☐ **Treatment x 12 months unless otherwise indicated below**<br>☐ **Treatment length x _____ month(s) or _____ weeks, frequency at every _____ week(s) or _____ month(s)**<br><br>**See package insert for additional warnings and precautions**<br>Note: Insurance company may require use of biosimilar | |

## Laboratory Orders

☐ **CBC** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **CMP** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **CRP** ☐ **Before each infusion** ☐ **Frequency:** _____

☐ **TB** **Every:** _____

## Notes

✓ **In event of infusion reaction, follow Adverse Reaction Protocols for treatment.**

☐ **Infusion reaction special orders:** _____

## Prescriber Information

Prescriber Name: _____ Prescriber Phone: _____

By signing below, I certify that the above therapy is medically necessary, and I authorize treatment.

_____ _____

Substitution allowed Dispense as written

Date: _____ Date: _____

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