HUMIRA® Infusion Form

Fax Referral To:
877-438-9380

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ________________ Next Infusion Date: ________________

Patient Information

Patient Name: ______________________ DOB: ____________ Sex: M F Height: ______ Weight: ______________

Phone Number: ______________________ Email Address: ______________________

Allergies: ______________________ Is the patient Diabetic: Y N ICD-10 Code: ______________

Emergency Contact: ______________________ Phone Number: ______________________

Primary Diagnosis:

________Crohn's Disease
________Rheumatoid Arthritis
________Ankylosing Spondylitis
________Psoriatic Arthritis
________Other: ______________________

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

Obtain liver enzymes at baseline and every six months thereafter

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:
Remicade Orencia Enbril Cimzia Date:____________

2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:____________

Physician Information

Prescribing Physician: ______________________ Practice Name: ______________________
Practice Phone: ______________________ Practice Fax: ______________________
Email: ______________________ Office Contact: ______________________
Co-managing Physician: ______________________ Phone/Email: ______________________

Medication Order

Medication: **HUMIRA® (adalimumab)**

New Start:

40 mg /0.8ml Pen **40mg/0.8ml Prefilled Syringe**

Inject 40mg sub-q ONCE a week
Inject 40mg sub-q every OTHER week

Refill: ____________ (1 monthly supply)

Pre-Medication Orders: No Pre-Meds recommended

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ ______________________
Physician's NPI# Physician's Address

______________________ ______________________
Prescriber's Signature Date

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