



PATIENT INFORMATION: Fax completed form, insurance information, and clinical documentation to 240.892.3005

Patient Name: _____ DOB: _____ Phone: _____

MEDICAL INFORMATION

Patient Weight: _____ lbs./kg. (required) Patient Height: _____ Allergies: _____

Diagnosis: _____ <input type="checkbox"/> Rheumatoid Arthritis, Unspecified <input type="checkbox"/> Unspecified Iridocyclitis <input type="checkbox"/> Arthropathic Psoriasis, Unspecified <input type="checkbox"/> Rheumatoid Arthritis w/ Rheumatoid Factor, Unspecified <input type="checkbox"/> Rheumatoid Arthritis w/out Rheumatoid Factor, Unspecified	ICD-10 Code: _____ <input type="checkbox"/> Ankylosing Spondylitis, Unspecified <input type="checkbox"/> Gout <input type="checkbox"/> Wegener's Granulomatosis <input type="checkbox"/> Systemic Lupus Erythematosus <input type="checkbox"/> Other: _____
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Drug	Dosing	Refill
Actemra	<input type="checkbox"/> 4 mg/kg IV every 4 weeks for ____ doses, then 8mg/kg IV every 4 weeks <input type="checkbox"/> 4mg/kg IV every 4 weeks <input type="checkbox"/> 8mg/kg IV every 4 weeks <input type="checkbox"/> Other dose: _____ mg IV every _____ weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Adakveo	<input type="checkbox"/> 5 mg/kg IV at Week 0, Week 2, then every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Krystexxa	<input type="checkbox"/> 8mg IV every 2 weeks Pre-medication protocol: Diphenhydramine 50mg PO, Methylprednisolone 125mg IV, Acetaminophen 1000mg PO	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Immunoglobulin (Ig)	<input type="checkbox"/> IV <input type="checkbox"/> SubQ Brand: _____ <i>Active Infusions to choose if not indicated</i> <input type="checkbox"/> _____ gm/kg x _____ day(s) OR divided over _____ day(s) <input type="checkbox"/> _____ mg/kg x _____ day(s) OR divided over _____ day(s) Frequency: Every _____ weeks OR _____	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Orencia	Dose: _____ mg IV Frequency: <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> 0, 2, 4 weeks and every 4 weeks thereafter	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Simponi Aria	<input type="checkbox"/> Initial Dose: 2mg/kg IV at weeks 0, 4, and then every 8 weeks <input type="checkbox"/> Maintenance Dose: 2mg/kg IV every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Stelara	Initial Dose: <input type="checkbox"/> 45mg SubQ initially, at 4 weeks, then 45mg SubQ every 12 weeks <input type="checkbox"/> 90mg SubQ initially, at 4 weeks, then 90mg SubQ every 12 weeks Maintenance Dose: <input type="checkbox"/> 45mg SubQ every 12 weeks OR <input type="checkbox"/> 90mg SubQ every 12 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Infliximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: _____ mg/kg IV Frequency: <input type="checkbox"/> Every _____ weeks OR <input type="checkbox"/> 0, 2, 6, then every 8 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Rituximab	<input type="checkbox"/> May substitute biosimilar per insurance requirement <input type="checkbox"/> Do not substitute. Brand: _____ Dose: <input type="checkbox"/> 1000mg OR <input type="checkbox"/> 375mg/m ² OR <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> One-time dose OR <input type="checkbox"/> Weekly x 4 weeks OR <input type="checkbox"/> Day 0, repeat dose in 2 weeks Pre-medication protocol: Benadryl 50mg IV/PO & Solu-Medrol 100mg IV	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year
Saphnelo	<input type="checkbox"/> 300mg IV every 4 weeks	<input type="checkbox"/> _____ <input type="checkbox"/> x 1 year

Premedication orders: Tylenol 1000mg 650 mg PO OR 500 mg PO
 Please choose one antihistamine Diphenhydramine 25mg PO/IV Diphenhydramine 50mg PO/IV Loratadine 10mg PO
 Cetirizine 10mg PO Other: _____
 Additional premedications: Solu-Medrol _____ mg IVP Solu-Cortef _____ mg IVP Other: _____

PROVIDER INFORMATION

Please provide the patient's demographic information, insurance information, medication list, and clinical notes. Active Infusions will complete insurance verification and submit required documentation for approval. Thank you for the referral.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

ACTIVE INFUSIONS | Patient Demographics Request

Dear Provider / Office Staff,

We have received a referral for the above patient and will be reaching out to begin the scheduling process. To ensure we are able to make contact in a timely manner, we kindly ask that your office confirm or complete the patient demographic information below. This helps us verify accurate contact details prior to outreach and avoid any delays in care.

Please complete and return via fax to 240-892-3005 or email kendrick@activeinfusions.com. Thank you!

PATIENT CONTACT INFORMATION

Please confirm or provide the most current contact information you have on file for this patient.

Patient Name

Last, First MI

Date of Birth

MM / DD / YYYY

Primary Phone Number

Best phone number

Alternate Phone Number

Alternate number

Email Address

Patient email address

Patient's Preferred Method of Contact:

Phone Call Text Message Email No Preference

EMERGENCY CONTACT

Required for ALL patients receiving therapy for Alzheimer's Disease

Emergency Contact Name

Full name

Relationship to Patient

e.g. Spouse, Child, Friend

Emergency Contact Phone

Phone number

Emergency Contact Email

Email (if available)

PRIMARY INSURANCE: SUBSCRIBER INFORMATION

Please confirm the subscriber / policy holder information for the patient's primary insurance.

Is the patient the Subscriber / Policy Holder?

Yes No

Subscriber / Policy Holder Name

Full name

Relationship to Patient

e.g. Self, Spouse, Parent

Subscriber Date of Birth

MM / DD / YYYY

Subscriber Member ID

Member ID

Insurance Company

Insurance name

Group Number

Group number

COPAY ASSISTANCE PROGRAM

If the patient is enrolled in a manufacturer copay or patient assistance program, please provide details if available.

Program Name

Program name

Program ID Number

ID number on card

NOTES / ADDITIONAL INFORMATION