FACTOR ONE SOURCE FAST PHARMACY
FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

GASTROENTEROLOGY FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA: ☐ Allergy:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____
Please attach a copy of the front and back of the patient's insurance card, if available.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis: ☐ K50.00 Crohn's Disease ☐ K51.90 Ulcerative Colitis ☐ Other:_____
Prior Med Failed: _____ Length of Treatment:_____Reason for D/C:_____
_____ Length of Treatment:_____Reason for D/C:_____
_____ Length of Treatment:_____Reason for D/C:_____
TB/PPD test: ☐ Pos ☐ Neg Date Read:_____

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____
By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.
Prescriber Printed Name:_____Date:_____
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Cimzia®	☐ 200mg X2 PFS	☐ Inject 400mg SC at weeks 0, 2, and 4 ☐ Inject 400mg once monthly ☐ Inject 200mg every other week	☐ 1 month supply	_____
☐ Entyvio®	☐ 300mg/ml vial	☐ Initial: Infuse 300mg over 30 minutes at weeks 0, 2 and 6 ☐ Maintenance: Infuse 300mg over 30 minutes every 8 weeks	☐ 1 month supply	_____
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SubQ once a week ☐ Inject 40mg SubQ every other week ☐ Inject 160mg SubQ day 1, 80mg day 15, then 40mg every other week (per Humira starter kit)	☐ 1 month supply	_____
☐ Remicade®	☐ 100mg vial	☐ Inject _____mg at weeks 0, 2, and 6 ☐ Inject _____mg every _____weeks	_____ _____	_____
☐ Simponi®	☐ 100mg Pen			
☐ Stelara®	☐ 130mg/26ml vial ☐ 90mg PFs ☐ 250mL NaCl bag	☐ Up to 55kg, infuse 260mg (2 vials) as a single IV infusion. ☐ Greater than 55kg to 85kg, infuse 390mg (3 vials) as a single IV infusion. ☐ Greater than 85kg, infuse 520mg (4 vials) as a single IV infusion ☐ Inject 90mg SubQ every 8 weeks	_____	_____
☐ OTHER	_____	_____	_____	_____