FACTOR ONE SOURCE FAST PHARMACY

**FAX 1-844-504-3278**
**PHONE 1-877-327-8881**
**www.FASTACCESSRX.com**

# RHEUMATOLOGY INFUSION 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: ☐ M06.9 Rheumatoid Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ M32.10 Systemic Lupus Erythematosus
☐ K50.00 Crohn's Disease ☐ 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 ☐ Positive ☐ Negative Date Read:_____

## PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
DATE:_____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 Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
*Substitution Allowed* *Dispense as Written*

## PRESCRIPTION:

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Actemra® | | Infuse ☐ 80mg ☐ 200mg ☐ 400mg every 4 weeks | 1 month supply | _____ |
| ☐ Benlysta® | ☐ 120mg/vial<br>☐ 400mg/vial | ☐ Loading Dose: Infuse _____ mg at weeks 0,2,and 4<br>☐ Maintenance Dose: Infuse _____mg every 4 weeks | 1 month supply | _____ |
| ☐ Boniva® | 3mg/ml | Inject 3mg every 3 months | 1 month supply | _____ |
| ☐ Cimzia® | 200mg/vial | Infuse_____ | 1 month supply | _____ |
| ☐ Cyclophosphamide | _____ | Infuse_____ | 1 month supply | _____ |
| ☐ Krystexxa® | 8mg vial | Infuse_____ | 1 month supply | _____ |
| ☐ Orencia® | 250mg vial | Infuse_____ | 1 month supply | _____ |
| ☐ Reclast® | 5mg/100ml | Infuse_____ | 1 month supply | _____ |
| ☐ Remicade® | 100mg vial | Infuse_____ | 1 month supply | _____ |
| ☐ Rituxan® | ☐ 100mg vial<br>☐ 500mg vial | Infuse_____ | 1 month supply | _____ |
| ☐ Simponi Aria® | 50mg/4ml | Infuse_____ | 1 month supply | _____ |
| ☐ Solu-Medrol® | _____ | Inject_____ | 1 month supply | _____ |
| ☐ Bivigam | | Infuse _____ | 1 month supply | _____ |
| ☐ Carimune | | Infuse _____ | 1 month supply | _____ |
| ☐ Flebogamma 5% | | Infuse _____ | 1 month supply | _____ |
| ☐ Gammagard S/D | | Infuse _____ | 1 month supply | _____ |
| ☐ Gammagard 10% | | Infuse _____ | 1 month supply | _____ |
| ☐ Gammaked | | Infuse _____ | 1 month supply | _____ |
| ☐ Gammaplex | | Infuse _____ | 1 month supply | _____ |
| ☐ Gamunex 10% | | Infuse _____ | 1 month supply | _____ |
| ☐ Octagam | | Infuse _____ | 1 month supply | _____ |
| ☐ Privigen 10% | | Infuse _____ | 1 month supply | _____ |
| ☐ _____ | _____ | _____ | 1 month supply | _____ |