FACTOR ONE SOURCE FAST PHARMACY

FAX 1-844-504-3278
PHONE 1-833-367-3278
www.FOSRXFAST.com

DERMATOLOGY FORM

PATIENT INFORMATION:

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

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: ☐ L40.50 Psoriatic Arthritis ☐ L40.0 Moderate to Severe Plaque Psoriasis ☐ L73.2 Hidradenitis
☐ 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:_____
Location: ☐ Hands ☐ Feet ☐ Scalp ☐ Groin ☐ Nails ☐ Other:_____%BSA_____
TB/PPD test: ☐ Pos ☐ Neg Date Read:_____ ☐ Humira® or Enbrel® home health training required

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 FOSRX/FAST 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
☐ 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	_____
☐ Cosentyx®	☐ 300mg (2x150) Pen ☐ PFS ☐ 150mg Pen ☐ PFS *Covered Until You're Covered	☐ Load: Inject ☐300mg or ☐150mg SubQ week 0,1,2,3,4 ☐ Maintenance: Inject ☐300mg or ☐150mg SubQ every 4 weeks ☐ Free Drug Load: Inject ☐300mg or ☐150mg SubQ week 0,1,2,3,4* ☐ Free Drug Maintenance: Inject ☐300mg or ☐150 mg SubQ every 4 weeks*	5 week supply 4 week supply 5 week supply 4 week supply	none _____ none _____
☐ Dupixent®	☐ 300mg/2ml PFS	☐ Inject 600mg (two 300mg injections in different injection sites) SC on day 0, then 300mg day 14 and day 28 ☐ Inject 300mg SC every other week	1 month supply	_____
☐ Enbrel®	☐ 50mg Sureclick ☐ 50mg PFS ☐ 25mg Vials ☐ 25mg PFS	☐ Inject 50mg once weekly ☐ Inject 50mg twice weekly ☐ Inject 25mg twice weekly	1 month supply	_____
☐ Humira®	☐ 40mg Pen ☐ 40mg PFS	☐ Inject 40mg SubQ once a week ☐ Inject 40mg SubQ every other week ☐ Inject 80mg day 1, then 40mg day 8, then 40mg every other week ☐ Inject 160mg day 1, then day 15 inject 80mg, then starting day 29 inject 40mg every week	1 month supply	_____
☐ Otezla®	☐ 30mg tablet ☐ Starter Pack	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily ☐ Starter Pack: Take 1 tablet by mouth day 1, then take 1 tablet by mouth twice daily as directed	1 month supply	_____
☐ Simponi®	☐ 50mg Smartject ☐ 50mg PFS	☐ Inject 50mg SubQ once monthly	1 month supply	_____
☐ Stelara®	☐ 45mg PFS ☐ 90mg PFS	☐ Inject 45mg day 1 and week 4, then every 12 weeks ☐ Inject 45mg every 12 weeks ☐ Inject 90mg day 1 and week 4, then every 12 weeks ☐ Inject 90mg every 12 weeks	1 month supply	_____
☐ Tremfya™	☐ 100mg PFS	☐ Inject 100mg SubQ on week 0 and week 4 ☐ Inject 100mg SubQ every 8 weeks	1 month supply	_____
☐ OTHER	_____	_____	_____	_____