FACTOR ONE SOURCE FAST PHARMACY

Phone: 1-833-FOS-FAST
Fax: 844-504-3278
Website: www.FOSRXFAST.com

Maryland Office
217 Glenn Street Ste 300
Cumberland, MD 21502

Louisiana Office
3131 N. 1-10 Service Rd. E., Ste. 202
Metairie, LA 70002

Texas Office
2600 W. Pleasant Run RD STE 1-173
Lancaster, TX 75146

Prescribing Practioner:	NPI:
Supervising Physician:	NPI:
Address:	Tax ID:
Office:	Fax:
Contact:	This prescription form is to be sent and received via fax.

Dermatology Enrollment Form: Humira

Faxed prescriptions will only be accepted from a prescribing practicioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to FOSRX/FAST.

PATIENT INFORMATION

Name:	M ☐ F ☐	DOB:	SS#:
Street:	City:	State:	Zip:
Telephone:	Alt. Tel:	English ☐ Spanish ☐ Other:	Wt: Ht:

PRESCRIPTION

New ☐ Refill ☐ Ship by: ___/___/___ Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug		Directions and Quantity	Refills
Humira® Citrate Free	☐ Psoriasis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
	☐ Adolescent HS Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADOLESCENT:** ****WEIGHT REQUIRED*****_____ ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg once a week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4) ****Intended for weight > 60 kg/132 lbs*****_____	
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MEDICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

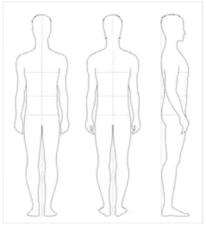
Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ Eucrisa	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA/UVB	☐ (_____)	☐	_____

☐ Patient Cannot Afford ☐ Photosensitivity ☐ Risk of skin cancer ☐ Distance from office

☐ L40.Psoriasis Vulgaris (Plaque Psoriasis)
☐ L73.2 Hidradenitis suppurativa
☐ L40.____ _____
☐ Other: _____

☐ Face
☐ Feet
☐ Groin
☐ Hands
☐ Nails
☐ Scalp
☐ Other: _____



Scoring Tool Used
☐ BSI ☐ EASI ☐ SCORAD
☐ POEM ☐ ISGA ☐ % or SCORE _____

Date of Diagnosis: ___/___/_____
Allergies: _____

Active TB is ruled out: ☐
Date: ___/___/_____
Hep B ruled out/treated: ☐
Date: ___/___/_____

AMERICAN ACADEMY OF DERMATOLOGY CONSENSUS STATEMENT ON PSORIASIS THERAPIES

☐ Psoriasis is covering greater than 10% body surface area
☐ Psoriasis is on palms, soles, head & neck, or genitals
☐ Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints
☐ Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment, or interpersonal relationships

INJECTION TRAINING

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ FOSRX/FAST to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner: **Date:**