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. |

# Rheumatology Enrollment Form: A-H

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 |
|---|---|---|---|
| Actemra® | ☐ Pre-filled Syringe<br>☐ Vials | ☐ **IV:** Infuse ____ mg OR ____ mg/kg via IV every 4 weeks (Quantity ___)<br>☐ **SQ:** Inject 162 mg SQ every **other** week (Quantity: 2)<br>☐ **SQ:** Inject 162 mg SQ every week (Quantity: 4) | |
| Cimzia® | ☐ Pre-filled Syringe<br>☐ Vials | ☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6)<br>☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2) | |
| Cosentyx™ | ☐ Sensoready Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 150 mg SQ on week 0,1, 2, 3, and 4 (Qty: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty: 1)<br>☐ **INITIAL**: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Qty: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty: 2) | |
| Cosentyx™<br>Covered Until You're Covered | ☐ Sensoready Pen<br>☐ Pre-filled Syringe | ☐ **INITIAL:** Inject 150 mg SQ on week 0,1, 2, 3, and 4 (Qty: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty: 1)<br>☐ **INITIAL**: Inject 300 mg SQ on week 0, 1, 2, 3, and 4 (Qty: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty: 2) | |
| Enbrel® | ☐ SureClick® Pen<br>☐ Mini™ with AutoTouch™<br>☐ Pre-filled Syringe<br>☐ 25 mg ☐ 50 mg<br>☐ Vials 25 mg | ☐ Inject 50 mg SQ every week (Quantity: 4)<br>☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8) | |
| Humira® Citrate Free | ☐ Uveitis Starter Kit<br>☐ Pen<br>☐ Pre-filled Syringe | ☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3)<br>☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4) | |
| Humira® | ☐ Uveitis Starter Kit<br>☐ Pen<br>☐ Pre-filled Syringe | ☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg ever other week (Quantity: 4)<br>☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)<br>☐ **MAINTENANCE:** Inject 40 mg SQ weekly (Quantity: 4) | |

## MEDICAL INFORMATION

| Previous Therapies: | Tried & Failed (Duration): | Not Tolerated: | Contraindication: |
|---|---|---|---|
| ☐ Methotrexate | ☐ (_____) | ☐ | _____ |
| ☐ Plaquenil | ☐ (_____) | ☐ | _____ |
| ☐ Meloxicam | ☐ (_____) | ☐ | _____ |
| ☐ Naproxen / Aleve | ☐ (_____) | ☐ | _____ |
| ☐ Tramadol | ☐ (_____) | ☐ | _____ |
| ☐ Enbrel | ☐ (_____) | ☐ | _____ |
| ☐ Humira | ☐ (_____) | ☐ | _____ |
| ☐ Cimzia | ☐ (_____) | ☐ | _____ |
| ☐ _____ | ☐ (_____) | ☐ | _____ |
| ☐ _____ | ☐ (_____) | ☐ | _____ |

- ☐ H20.9 Unspecified Iridocyclitis
- ☐ M06.9 Rheumatoid Arthritis, Unspecified
- ☐ M31.6 Other Giant Cell Arteritis
- ☐ M45.9 Ankylosing Spondylitis, Unspecified
- ☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
- ☐ H20.9 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
- ☐ M05.9 Rheumatoid Arthritis, with Rheumatoid Factor, Unspecified
- ☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ Other: _____

Date of Diagnosis: ____/____/_____
Allergies: _____

Active TB is ruled out:
Date: ____/____/_____
Hep B ruled out/treated:
Date: ____/____/_____
Additional Clinical Info: _____

## 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:**

## CONFIDENTIALITY NOTICE

**IMPORTANT:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error please destroy this document immediately.