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: I-Z

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
Kevzara®	☐ Pen ☐ 150 mg ☐ 200 mg ☐ Pre-filled Syringe ☐ 150 mg ☐ 200 mg	☐ Inject 150 mg SQ every 2 weeks (Quantity: 2) ☐ Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Olumiant®	☐ 2 mg Tablets	☐ Take 2 mg PO once daily (Quantity 30)	
Orencia®	☐ Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4 (Quantity: ____) ☐ **MAINTENANCE:** Infuse ____ mg via IV every 4 weeks (Quantity: ____) **SUBCUTANEOUS (SQ):** ☐ Inject 125 mg SQ once weekly (Quantity: 4)	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month. (Quantity: 1)	
Xeljanz®	☐ 5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)	
Xeljanz® XR	☐ 11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)	

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	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ M05.9 Rheumatoid Arthritis, with Rheumatoid Factor, Unspecified
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ 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