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: A-E

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:_____

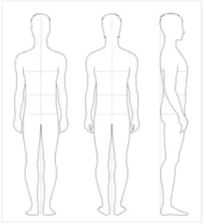
Drug		Directions and Quantity	Refills
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ (two 200 mg injections) every other week (Quantity: 4)	
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 300 mg SQ on week 0,1, 2, 3, and 4 (Qty: 10) ☐ **MAINTENANCE**: Inject 300 mg SQ every 4 weeks (Qty: 2)	
Cosentyx™ Covered Until You're Covered	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **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)	
Dupixent®	☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections in different injection sites) ☐ **MAINTENANCE**: Inject 300 mg SQ every **other** week	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	**ADULT:** ☐ **INITIAL:** Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) ☐ **MAINTENANCE:** Inject 50 mg SQ weekly (Quantity 4) **PEDIATRIC:** ***WEIGHT REQUIRED*** _____ ☐ Inject ____ mg (0.8 mg/kg x ___kg SQ every week) **(Less than or equal to 63 kg)** (Quantity: QS 1 month) ☐ Inject 50 mg SQ every week **(Greater than 63 kg)** (Quantity: 4)	

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	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

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



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

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

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

Date of Diagnosis: ____/____/_____

☐ Active TB is ruled out:
Date: ____/____/_____

☐ Hep B ruled out/treated:
Date: ____/____/_____

☐ L40.Psoriasis Vulgaris (Plaque Psoriasis)
☐ L20.9 Atopic Dermatitis (Moderate to Severe)
☐ L40.____ _____
☐ Other: _____

Additional Clinical Information:

Allergies:

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:**