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.

Gastrointestinal 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
Remicade®	☐ Vials	☐ **INITIAL:** Infuse _____ mg IV on day 0, 14, and 42 (Quantity: ____) ☐ **MAINTENANCE**: Infuse _____ mg IV every 8 weeks (Quantity: ____)	
Simponi®	☐ 100 mg SmartJect® Pen ☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 200 mg SQ on day 0, then 100 mg on day 14 (Quantity: 3) ☐ **MAINTENANCE**: Inject 100 mg SQ every 4 weeks (Quantity: 1)	
Stelara®	☐ 130 mg/26mL Vials ☐ Pre-filled Syringe **Weight Required:** _____	☐ **INITIAL INTRAVENOUS DOSAGE:** A single intravenous infusion using weight-based dosing: Up to 55kg=260mg (2 vials), >55kg to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials) ☐ **MAINTENANCE**: Inject 90 mg SQ 8 weeks after initial dose, then every 8 weeks thereafter (1 syringe)	
Xeljanz®	10 mg Tablets	☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	5 mg Tablets	☐ **MAINTENANCE**: Take 5 mg PO twice daily (Quantity: 60)	
	10 mg Tablets	☐ **MAINTENANCE**: Take 10 mg PO twice daily (Quantity 60)	

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	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Pentasa	☐ (_____)	☐	_____
☐ Entocort	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Allergies:

Additional Clinical Information:

☐ K50.00 Crohn's disease of small intenstine, without complications
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ Other: _____

Date of Diagnosis: ____/____/_____

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

Hep B ruled out/treated: ☐ 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.

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:**