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: 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
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg (two 200 mg injections) SQ on day 0, 14, and 28 (Quantity: 6) ☐ **MAINTENANCE**: Inject 400 mg (two 200 mg injections) SQ every 4 weeks (Quantity: 2)	
Entyvio™	☐ Vials	☐ **INITIAL:** Infuse 300 mg IV over 30 minutes at day 0, 14, and 42 (Quantity: 3) ☐ **MAINTENANCE**: Infuse 300 mg IV over 30 minutes every 8 weeks (Quantity: 1)	
Humira® *Citrate Free*	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg every **other** week starting on day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC:** ***WEIGHT REQUIRED***_____ ☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 15, then 20 mg every **other** week starting day 29 (Quantity: 2) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17kg/37 lbs to <40kg 88 lbs***	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15, then 40 mg every other week starting on day 29 (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight ≥ 40kg 88 lbs***	
Humira®	☐ Adult Crohn's/UC Starter Kit ☐ Pen ☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg on Day 15 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2)	
	☐ Pediatric Crohn's Starter Kit ☐ Pre-filled Syringe 20 mg	**PEDIATRIC:** ***WEIGHT REQUIRED***_____ ☐ **INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 15, then 20 mg every **other** week starting day 29 (Quantity: 3) ☐ **MAINTENANCE:** Inject 20 mg SQ every **other** week (Quantity: 2) ***Intended for weight 17kg/37 lbs to <40kg 88 lbs***	
	☐ Pediatric Crohn's Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 160 mg SQ on Day 1, 80 mg Day 15, then 40 mg every other week starting on day 29 (Quantity: 6) ☐ **MAINTENANCE:** Inject 40 mg SQ every **other** week (Quantity: 2) ***Intended for weight ≥ 40kg 88 lbs***	

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:**