

**Dermatology
Enrollment Form:
A-E**



**FACTOR ONE SOURCE
FAST**
PHARMACY
Powered By: InfuCare Rx

Phone: 1-833-FOS-FAST
Fax: 844-504-3278
Website: www.FOSRXFAST.com
Louisiana Office
3131 N. 1-10 Service Rd. E., Ste. 202
Metairie, LA 70002

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescribing Practitioner:		NPI:	
Address:				Supervising Physician:		NPI:	
City:		State/Zip:		Address:		DEA:	
Telephone:		DOB: ___/___/___	M <input type="checkbox"/> F <input type="checkbox"/>	Office:		Phone:	
Language Preference:			Wt:	Ht:	Contact:		Fax:

PRESCRIPTION

New Refill Ship by: ___/___/___ Ship to: Patient's Home Doctor's Office Other: _____

Drug	Directions and Quantity	Refills
Cimzia® <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> Vials	<input type="checkbox"/> INITIAL: Inject 400 mg SQ (two 200 mg injections) every other week (Quantity: 4)	
Cosentyx™ <input type="checkbox"/> 150 mg Sensoready Pen <input type="checkbox"/> 150 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg SQ on week 0, 1, 2, 3, and 4, then maintenance dose (Qty: 10) <input type="checkbox"/> MAINTENANCE: Inject 150 mg SQ every 4 weeks (Qty: 2)	
	<input type="checkbox"/> INITIAL: Inject 300 mg (two 150 mg injections) SQ on week 0, 1, 2, 3, and 4, then maintenance dose (Qty: 10) <input type="checkbox"/> MAINTENANCE: Inject 300 mg (two 150 mg injections) SQ every 4 weeks (Qty: 2)	
Dupixent® <input type="checkbox"/> Pre-filled Syringe	ADULT: <input type="checkbox"/> INITIAL: Inject 600 mg SQ (two 300 mg injections in different injection sites) <input type="checkbox"/> MAINTENANCE: Inject 300 mg SQ every other week	
Enbrel® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with AutoTouch™ <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> Vials 25 mg	ADULT: <input type="checkbox"/> INITIAL: Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) <input type="checkbox"/> MAINTENANCE: Inject 50 mg SQ weekly (Quantity 4)	
	PEDIATRIC: ***WEIGHT REQUIRED*** <input type="checkbox"/> Inject ___ mg (0.8 mg/kg x ___ kg SQ every week) (Less than or equal to 63 kg) (Quantity: QS 1 month) <input type="checkbox"/> 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: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Soriatane <input type="checkbox"/> Clobetasol <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Eucrisa <input type="checkbox"/> Stelara <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: _____ _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____	
PHOTOTHERAPY <input type="checkbox"/> UVA/UVB <input type="checkbox"/> Patient Cannot Afford	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: <input type="checkbox"/> Distance from office	Scoring Tool Used <input type="checkbox"/> BSI <input type="checkbox"/> EASI <input type="checkbox"/> SCORAD <input type="checkbox"/> POEM <input type="checkbox"/> ISGA <input type="checkbox"/> % or SCORE _____	
<input type="checkbox"/> L40.Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> L20.9 Atopic Dermatitis (Moderate to Severe)	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/>	Contraindication: <input type="checkbox"/> L40._____ <input type="checkbox"/> Other: _____	Date of Diagnosis: ___/___/___ <input type="checkbox"/> Active TB is ruled out: Date: ___/___/___ <input type="checkbox"/> Hep B ruled out/treated: Date: ___/___/___	
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 Signature: _____ **Date:** _____