

**Dermatology
Enrollment Form:
I-Z**



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

**Phone: 1-833-367-3278
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:			Wt:	Ht:	Contact:		Fax:

PRESCRIPTION

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

Drug	Directions and Quantity	Refills
Ilumya™ <input type="checkbox"/> 100 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 100 mg SQ on week 0, and 4 (Qty: 2) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 12 weeks (Qty: 1)	
Otezla® <input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> Maintenance <input type="checkbox"/> Bridge Dose Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55) <input type="checkbox"/> 14 day titration starter pack sample provided by MD office <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 30) Continuation of Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 28) (12 refills) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 28) (6 refills)	
Siliq™ <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 210 mg SQ on weeks 0 & 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	
Skyrizi™ <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg (two 75 mg injections) SQ on weeks 0, 4, and every 12 weeks thereafter. <input type="checkbox"/> Physician administered <input type="checkbox"/> Patient administered	
Stelara® <input type="checkbox"/> 45 mg Vial (Pediatric ≤ 60 kg) <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 45 mg <input type="checkbox"/> 90 mg Weight Required: _____	<input type="checkbox"/> INITIAL: Inject SQ on day 0 and day 28 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject SQ every 12 weeks (Quantity: 1)	***WEIGHT BASED GUIDELINES*** PEDIATRIC: Less than 60 kg (132.2 lbs): 0.75 mg/kg 60 kg-100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90 mg ADULT: Less than or equal to 100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90 mg
Taltz® <input type="checkbox"/> SureClick® Pen <input type="checkbox"/> Mini™ with AutoTouch™	<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) <input type="checkbox"/> Inject 50 mg SQ every week (Greater than 63 kg) (Quantity: 4)	
Tremfya™ <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 210 mg SQ on weeks 0 & 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	

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"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <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"/> Photosensitivity <input type="checkbox"/> Risk of skin cancer	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"/> Other: _____				Date of Diagnosis: _____ <input type="checkbox"/> Active TB is ruled out: Date: _____ <input type="checkbox"/> Hep B ruled out/treated: Date: _____	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: _____