Rheumatology Enrollment Form

Phone: 1-833-FOS-FAST
Fax: 844-533-1131
Website: www.FOSRXFAST.com
Louisiana Office
3131 N. 1-10 Service Rd. E., Ste. 202
Metairie, LA 70002

PATIENT INFORMATION			PRESCRIBER INFORMATION	
Name:			Prescribing Practioner:	NPI:
Address:			Supervising Physician:	NPI:
City:	State/Zip:		Address:	DEA:
Telephone:	DOB: ___/___/____	M ☐ F ☐	Office:	Phone:
Language Preference:	Wt:	Ht:	Contact:	Fax:

PRIMARY INSURANCE INFORMATION

Member Name:	M ☐ F ☐	DOB: ___/___/____	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:		

PRESCRIPTION

New ☐ Refill ☐ | Ship by: ___/___/____ | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:________________________

Drug		Directions	Quantity	Refills
Actemra®		Infuse: ☐ 80mg ☐ 200mg ☐ 400mg every 4 weeks	1 month supply	
Benlysta®	☐ 120mg/vial ☐ 400mg/vial	☐ Loading Dose: Infuse ______ mg at weeks 0,2, and 4 ☐ Maintenance Dose: Infuse ______ mg every 4 weeks	4 week supply	
Boniva®	☐ 3mg/ml	☐ Inject 3 mg every 3 months	1 month supply	
Cimzia®	☐ 200mg/vial	☐ Infuse: ____	1 month supply	
Krystexxa®	☐ 8mg/vial	☐ Infuse: ____	1 month supply	
Orencia®	☐ 250mg vial	☐ Infuse: ____	1 month supply	
Reclast®	☐ 5mg/100ml	☐ Infuse: ____	1 month supply	
Remicade®	☐ 100mg vial	☐ Infuse: ____	1 month supply	
Rituxan®	☐ 100mg vial ☐ 500mg vial	☐ Infuse: ____	1 month supply	
Simponi Aria®	☐ 50mg/4ml	☐ Infuse: ____	1 month supply	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

☐ M06.9 Rheumatoid Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.10 Systemic Lupus Erythematosus
☐ K50.00 Crohn's Disease
☐ Other: ____

TB/PPD test: ☐ Positive ☐ Negative Date Read: ________________

Patient Weight: ________ ☐ kg ☐ lbs Height: _______ ☐ cm ☐ in

Allergies: ____

Lab Data: ____

Prior Medication Failed: ____

Length of Treatment:____

Reason for Discontinuation: ____

Additional Clinical Information:

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:**