Dermatology Enrollment Form: A-E

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

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Louisiana Office
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Kenner, LA 70062

PATIENT INFORMATION / PRESCRIBER INFORMATION

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:

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 SQ (two 200 mg injections) every other week (Quantity: 4)	
Cosentyx™	☐ 150 mg Sensoready Pen ☐ 150 mg Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0,1, 2, 3, and 4, then maintenance dose (Qty: 10) ☐ **MAINTENANCE**: Inject 150 mg SQ every 4 weeks (Qty: 2)	
		☐ **INITIAL:** Inject 300 mg (two 150 mg injections) SQ on week 0,1, 2, 3, and 4, then maintenance dose (Qty: 10) ☐ **MAINTENANCE**: Inject 300 mg (two 150 mg injections) SQ every 4 weeks (Qty: 2)	
Dupixent®	☐ Pre-filled Syringe	**ADULT:** ☐ **INITIAL:** Inject 600 mg SQ (two 300 mg injections in different injection sites) ☐ **MAINTENANCE**: Inject 300 mg SQ every **other** week	
Enbrel®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™ ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	**ADULT:** ☐ **INITIAL:** Inject 50 mg SQ twice weekly (72-96 hours apart) for 3 months (Quantity: 8 with 2 refills) ☐ **MAINTENANCE:** Inject 50 mg SQ weekly (Quantity 4)	
		PEDIATRIC: ***WEIGHT REQUIRED*** ________ ☐ Inject ____ mg (0.8 mg/kg x ___kg SQ every week) **(Less than or equal to 63 kg)** (Quantity: QS 1 month) ☐ 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:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (______________)	☐	____________________
☐ Soriatane	☐ (______________)	☐	____________________
☐ Clobetasol	☐ (______________)	☐	____________________
☐ Hydrocortisone	☐ (______________)	☐	____________________
☐ Eucrisa	☐ (______________)	☐	____________________
☐ Stelara	☐ (______________)	☐	____________________
☐ Humira	☐ (______________)	☐	____________________
☐ Enbrel	☐ (______________)	☐	____________________
☐ ______________	☐ (______________)	☐	____________________
PHOTOTHERAPY	**Tried & Failed (Duration):**	**Not Tolerated:**	**Contraindication:**
☐ UVA/UVB	☐ (______________)	☐	____________________

☐ Patient Cannot Afford ☐ Photosensitivity ☐ Risk of skin cancer ☐ Distance from office

☐ Face
☐ Feet
☐ Groin
☐ Hands
☐ Nails
☐ Scalp
☐ Other: __________

Scoring Tool Used
☐ BSI ☐ EASI ☐ SCORAD
☐ POEM ☐ ISGA ☐ % or SCORE _____

Date of Diagnosis: ____/____/_______

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

☐ Hep B ruled out/treated: Date: ____/____/_______

☐ L40.Psoriasis Vulgaris (Plaque Psoriasis)
☐ L20.9 Atopic Dermatitis (Moderate to Severe)
☐ L40.____ ____
☐ Other: ____

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:**