Dermatology Enrollment Form: I-Z

FACTOR ONE SOURCE FAST PHARMACY
Powered By: InfuCare Rx

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Louisiana Office
2400 Veterens Blvd. Suite 480
Kenner, LA 70062

PATIENT INFORMATION

Name:
Address:
City: State/Zip:
Telephone: DOB: ___/___/____ M ☐ F ☐
Language: Wt: Ht:

PRESCRIBER INFORMATION

Prescribing Practioner: NPI:
Supervising Physician: NPI:
Address: DEA:
Office: Phone:
Contact: Fax:

PRESCRIPTION

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

Drug		Directions and Quantity	Refills
Ilumya™	☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 100 mg SQ on week 0, and 4 (Qty: 2) ☐ **MAINTENANCE**: Inject 100 mg SQ every 12 weeks (Qty: 1)	
Otezla®	☐ 28 Day Starter Pack	☐ Take as directed per package instructions (Quantity: 55) ☐ 14 day titration starter pack sample provided by MD office	
	☐ Maintenance	☐ Take 30 mg PO twice daily (Quantity: 60) ☐ Take 30 mg PO once daily (Quantity: 30) **Continuation of Therapy:** ☐ Yes ☐ No	
	☐ Bridge Dose Pack	☐ Take 30 mg PO twice daily (Quantity: 28) (12 refills) ☐ Take 30 mg PO once daily (Quantity: 28) (6 refills)	
Siliq™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 210 mg SQ on weeks 0 & 1 (Quantity: 2) ☐ **MAINTENANCE**: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)	
Skyrizi™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg (two 75 mg injections) SQ on weeks 0, 4, and every 12 weeks thereafter. ☐ Physician administered ☐ Patient administered	
Stelara®	☐ 45 mg Vial (Pediatric ≤ 60 kg) ☐ Pre-filled Syringe ☐ 45 mg ☐ 90 mg Weight Required: _____	☐ **INITIAL:** Inject SQ on day 0 and day 28 (Quantity: 2) ☐ **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®	☐ SureClick® Pen ☐ Mini™ with AutoTouch™	☐ 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) ☐ Inject 50 mg SQ every week **(Greater than 63 kg)** (Quantity: 4)	
Tremfya™	☐ Pre-filled Syringe	☐ **INITIAL:** Inject 210 mg SQ on weeks 0 & 1 (Quantity: 2) ☐ **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:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Soriatane	☐ (_____)	☐	_____
☐ Clobetasol	☐ (_____)	☐	_____
☐ Hydrocortisone	☐ (_____)	☐	_____
☐ Eucrisa	☐ (_____)	☐	_____
☐ Stelara	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

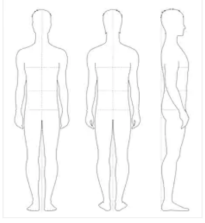
PHOTOTHERAPY	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ UVA/UVB	☐ (_____)	☐	_____

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

☐ L40.Psoriasis Vulgaris (Plaque Psoriasis) ☐ Other: _____

Additional Clinical Information:

☐ 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: _____

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:**