Rheumatology 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
2400 Veteran Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION

Name:
Address:
City: | State/Zip:
Telephone: | DOB: | M ☐ F ☐
Language Preference: | Wt: | Ht:

PRESCRIBER INFORMATION

Prescribing Practioner: | NPI:
Address:
City | State/Zip
Office: | DEA:
Contact: | Phone: | Fax:

PRIMARY INSURANCE INFORMATION

Member Name: | M ☐ F ☐ | DOB:
Address: | City:
State: | Zip: | Telephone: | Alt. Telephone:
Member ID: | Rx Group #: | BIN#:
PCN#: | Customer Service #: | New ☐ Refill ☐ | Ship by:

PRESCRIPTION

Drug		Directions	Quantity	Refills
Kevzara®	☐ Pen ☐ 150 mg ☐ 200 mg ☐ Pre-filled Syringe ☐ 150 mg ☐ 200 mg	☐ Inject 150 mg SQ every 2 weeks (Quantity: 2) ☐ Inject 200 mg SQ every 2 weeks (Quantity: 2)		
Olumiant®	☐ 2 mg Tablets	☐ Take 2 mg PO once daily (Quantity 30)		
Orencia®	☐ Vials ☐ Pre-filled Syringe ☐ ClickJect™	**INTRAVENOUS (IV):** ☐ **INITIAL:** Infuse _____ mg via IV on week 0, 2, and 4 (Quantity: ____) ☐ **MAINTENANCE:** Infuse ____ mg via IV every 4 weeks (Quantity: ____) **SUBCUTANEOUS (SQ):** ☐ Inject 125 mg SQ once weekly (Quantity: 4)		
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month. (Quantity: 1)		
Simponi Aria®	☐ 50 mg Vial Weight required: ________	☐ **INITIAL:** Infuse 2 mg/kg via IV over 30 minutes at weeks 0 and 4 (Quantity: QS doses) ☐ **MAINTENANCE:** Infuse 2 mg/kg via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose)		
Xeljanz®	☐ 5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)		
Xeljanz® XR	☐ 11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)		

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	☐ (________________)	☐	________________
☐ Plaquenil	☐ (________________)	☐	________________
☐ Meloxicam	☐ (________________)	☐	________________
☐ Naproxen / Aleve	☐ (________________)	☐	________________
☐ Tramadol	☐ (________________)	☐	________________
☐ Enbrel	☐ (________________)	☐	________________
☐ Humira	☐ (________________)	☐	________________
☐ Cimzia	☐ (________________)	☐	________________
☐ ________________	☐ (________________)	☐	________________

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ M05.9 Rheumatoid Arthritis, with Rheumatoid Factor, Unspecified
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ Other: ________________________________

Additional Clinical Info:

Date of Diagnosis: ____/____/_______
Allergies: ________________________________

Active TB is ruled out:
Date: ____/____/_______
Hep B ruled out/treated:
Date: ____/____/_______

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:**