

**Endocrinology
Enrollment Form**



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 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescribing Practitioner:		NPI:	
Address:				Address:			
City:		State/Zip:		City:		State/Zip:	
Telephone:		DOB:	M	F	Office:		
Language Preference:			Wt:	Ht:	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 #:			Please attach a copy of the front and back of the patient's insurance card, if available.*****	

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

Drug	Strength	Directions	Quantity	Refills
Forteo®	600mcg/2.4mL	Inject 20mcg SubQ daily	1 month supply	
Praluent®	75mg PFS	Inject 75mg SubQ once every 2 weeks	1 month supply	
	75mg Pen	Inject 150mg SubQ once every 2 weeks		
	150mg PFS			
	150mgPen			
Prolia®	60mg	Inject 60mg SubQ every 6 months	1 month supply	
Reclast®	5mg/100mL	Infuse 5mg once yearly	1 vial	
Repatha®	140mg/mL Sureclick	Inject 140mg every 2 weeks into abdomen, thigh, or upper arm Inject 420mg once monthly into abdomen, thigh, or upper arm (Give 3 injections within 30 minutes)	1 month supply	
Thyrogen®	2 vial kit	Inject 0.9mg IM day 1 followed by 0.9 IM day 2	1 kit	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION	
***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY	
E78.0 Pure Hypercholesterolemia (including HeFH and HoFH) E78.2 Mixed Hyperlipidemia E78.4 Other and Unspecified Hyperlipidemia Other: _____	LDL-C Treatment: Atovastatin Rosuvastatin Simvastatin Ezetimibe Other Dose: _____ Allergies:
Prior Medication Failed: _____ Length of Treatment: _____ Reason for Discontinuation: _____ Forteo® Home Health Training Required	

Additional Clinical Information:

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:
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