Nephrology Enrollment Form

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

Phone: 1-833-367-3278
Fax: 1-844-504-3278
Website: www.FOSRXFAST.com

Louisiana Office
2400 Veterans 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 Practitioner: | 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 #: | 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
Aranesp®			1 month supply	
Epogen®			1 month supply	
Procrit®			1 month supply	
Rayaldee®	30 mcg 60 mcg	Take 1 capsule by mouth daily	1 month supply	
Samsca®			1 month supply	
Sensipar®			1 month supply	
Zemplar®			1 month supply	

DIAGNOSIS AND CLINICAL INFORMATION

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

ICD-10 and Diagnosis:

Prior Medication Failed: ____

Length of Treatment:____

Reason for Discontinuation: ____

Lab Results: Hematocrit: _______________% Hemoglobin: ________________%
Date: ____/______/_________ Date: _____/_____/__________

Platelets: ________________%
Date: _____/_____/__________

Serrum Ferrite: ________________ng/mL Transferrin Saturation (TSAT):________________
Date: ____/____/________ Date: ____/____/________

Additional Clinical Information:

Allergies:

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:**