Neurology 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
Avonex®	☐ 30mcg PFS ☐ 30mcg vial	☐ Inject 30mcg IM once weekly ☐ Other: _____	1 month supply	
AIMOVIG®	☐ 70mg ☐ 140mg	☐ Inject 70mg SubQ once monthly ☐ Inject 140mg SubQ once monthly (2 70mg injections consecutively)	1 month supply	
Betaseron®	☐ 0.3mg PFS	☐ **Initial: Week 1&2**: 0.25ml (0.0625mg), **Week 3&4:** 0.5ml (0.125mg) **Week 5&6:** 0.075ml (0.1875mg), **Week 7+:** 1ml (0.25mg) SubQ every other day	1 month supply	
Copaxone®	☐ 20mg PFS	☐ **Maintenance:** Inject 1 mL (0.25mg) SubQ every other day	1 month supply	
Extavia®	☐ 0.3mg Kit	☐ Inject 20mg SubQ every day	1 month supply	
Gilenya™	☐ 0.5mg cap	☐ Take 1 capsule by mouth once daily	1 month supply	
Glatopa™	☐ 20mg PFS	☐ Inject 20mg SubQ every day	1 month supply	
Rebif®	☐ Titration Pack ☐ 22mcg PFS ☐ 44mcg PFS	☐ **Initial: Week 1&2:** 0.2ml (8.8mg), **Week 3&4:** 0.5ml (22mcg) SubQ three times weekly ☐ **Maintenance:** Inject 0.5ml (22mcg) SubQ three times weekly ☐ **Maintenance:** Inject 0.5ml (44mcg) SubQ three times weekly ☐ **Other:** _____	1 month supply	
Epipen®	☐ 2 pack	☐ Inject 1 pen into thigh in case of anaphylaxis	1 box of 2	
Epipen® Jr	☐			

Injection Training:

☐ Patient has received pen and injection training ☐ Physician's office to provide injection training ☐ FOSRX/FAST to coordinate injection training

DIAGNOSIS AND CLINICAL INFORMATION

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

Diagnosis Description and ICD10:

Additional Clinical Information:

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

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:**