Osteoporosis 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

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
Forteo®	☐ 600mcg/2.4mL	☐ Inject 20mcg subq daily	1 month supply	
Prolia®	☐ 60mg	☐ Inject 60mg subq every 6 months	1 month supply	
Reclast®	☐ 5mg/100mL	☐ Infuse 5mg once yearly	1 vial	
Tymlos®	☐ 2mg/mL	☐ Inject 80 mcg subq daily	1 month supply	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION

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

☐ M81.0 -Age- Related Osteoporosis without current pathological fracture
☐ Other: _____

T-score:_____
Prior Medication Failed: _____
Length of Treatment:_____
Reason for Discontinuation: _____
☐ Forteo® Home Health Training Required

TB/PPD test: ☐ Positive ☐ Negative Date Read: _____

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Lab Data: _____

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:**