Pulmonary Arterial Hypertension 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
Adcirca®	☐ 20mg		1 month supply	
Revatio®	☐ 20 mg		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

Diagnosis Description and ICD10:

☐ 127.0 Primary Pulmonary Hypertension

☐ Other: _____

Additional Clinical Information:

Expected Date of next dose: ____/____/_____

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:**