Rheumatology Enrollment Form: A-H

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

Faxed prescriptions will only be accepted from a prescribing practicioner. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to FOSRX/FAST.

This prescription form is to be sent and received via fax.

PATIENT INFORMATION

Name:	SSN#:		
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:

PRESCRIPTION

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

Drug		Directions	Refills
Actemra®	☐ Pre-filled Syringe ☐ Vials	☐ **IV**: Infuse _____mg OR _____ mg/kg via IV every 4 weeks (Quantity: _____) ☐ **SQ**: Inject 162 mg SQ every **other** week (Qunatity: 2) ☐ **SQ**: Inject 162 mg SQ every week (Quantity: 4)	
Cimzia®	☐ Pre-filled Syringe ☐ Vials	☐ **INITIAL:** Inject 400 mg SQ at Day 0, Day 14, and Day 28 (Quantity: 6) ☐ **MAINTENANCE:** Inject 400 mg SQ every 4 weeks (Quantity: 2) ☐ **MAINTENANCE:** Inject 200 mg SQ every 2 weeks (Quantity: 2)	
Cosentyx™	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0,1,2,3, and 4 (Qty: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty: 1) ☐ **INITIAL:** Inject 300 mg SQ on week 0,1,2,3, and 4 (Qty: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty: 2)	
Cosentyx™ Covered Until You're Covered	☐ Sensoready Pen ☐ Pre-filled Syringe	☐ **INITIAL:** Inject 150 mg SQ on week 0,1,2,3, and 4 (Qty: 5) ☐ **MAINTENANCE:** Inject 150 mg SQ every 4 weeks (Qty: 1) ☐ **INITIAL:** Inject 300 mg SQ on week 0,1,2,3, and 4 (Qty: 10) ☐ **MAINTENANCE:** Inject 300 mg SQ every 4 weeks (Qty: 2)	
Embrel®	☐ Pre-filled Syringe ☐ Mini™ with Autotouch™ ☐ Pre-filled Syringe ☐ 25 mg ☐ 50 mg ☐ Vials 25 mg	☐ Inject 50 mg SQ every week (Quantity: 4) ☐ Inject 25 mg SQ twice weekly 72-96 hours apart (Quantity: 8)	
Humira® CItrate Free	☐ Unveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every other week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	
Humira®	☐ Unveitis Starter Kit ☐ Pen ☐ Pre-filled Syringe	☐ **UVEITIS INITIAL:** Inject 80 mg SQ on Day 1, 40 mg on Day 8, then 40 mg every **other** week (Quantity: 3) ☐ **MAINTENANCE:** Inject 40 mg SQ every other week (Quantity: 2) ☐ **MAINTENANCE:** Inject 40 mg SQ every week (Quantity: 4)	

MEDICAL INFORMATION

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

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
☐ Methotrexate	☐ (_____)	☐	_____
☐ Plaquenil	☐ (_____)	☐	_____
☐ Meloxicam	☐ (_____)	☐	_____
☐ Naproxen / Aleve	☐ (_____)	☐	_____
☐ Tramadol	☐ (_____)	☐	_____
☐ Enbrel	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

- ☐ H20.9 Unspecified Iridocyclitis
- ☐ M06.9 Rheumatoid Arthitis, Unspecified
- ☐ M31.6 Other Giant Cell Arthritis
- ☐ M45.9 Ankylosing Spondylitis, Unspecified
- ☐ M31.5 Giant Cell Arteritis with Polymyalgia Rheumatica
- ☐ H20.9 Iridocyclitis (Uveitis), Unspecified Acute and Subacute
- ☐ M05.9 Rheumatoid Arthritis, with Rheumatoid Factor, Unspec-
- ☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
- ☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
- ☐ Other: _____

Date of Diagnosis: ____/____/_____
Allergies: _____

Active TB is ruled out:
Date: ____/____/_____
Hep B ruled out/treated:
Date: ____/____/_____

Additional Clinical Info:

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:**

CONFIDENTIALITY NOTICE