Transplant 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: | Organ Type: ☐ Heart ☐ Kidney ☐ Liver ☐ Lung ☐ Pancreas ☐ Other:_____

Drug	Strength	Directions	Quantity	Refills
☐ Aspirin®				
☐ Clotrimazole®				
☐ Colace®				
☐ Gengraf®				
☐ MVI®				
☐ Myfortic®				
☐ Noeral®				
☐ Nystatin®				
☐ Pepcid®				
☐ Prednisone®				
☐ Prograf®				
☐ Rapamune®				
☐ SMX/TMP®				
☐ Valcyte®				
☐ Other:				
☐ Other:				

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:

Allergies:

Date of Transplant: ____/____/_____

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:**