

**Dermatology
Enrollment Form:
I-Z**

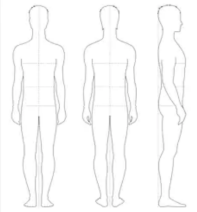


**FACTOR ONE SOURCE
FAST PHARMACY**
Powered By: InfuCare Rx

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				PRESCRIBER INFORMATION			
Name:				Prescribing Practitioner:		NPI:	
Address:				Supervising Physician:		NPI:	
City:		State/Zip:		Address:		DEA:	
Telephone:		DOB: ____/____/____	M <input type="checkbox"/> F <input type="checkbox"/>	Office:		Phone:	
Language:			Wt:	Ht:	Contact:		Fax:

PRESCRIPTION			
New <input type="checkbox"/> Refill <input type="checkbox"/>		Ship by: ____/____/____	
		Ship to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Other: _____	
Drug	Directions and Quantity	Refills	
Ilumya™ <input type="checkbox"/> 100 mg Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 100 mg SQ on week 0, and 4 (Qty: 2) <input type="checkbox"/> MAINTENANCE: Inject 100 mg SQ every 12 weeks (Qty: 1)		
Otezla® <input type="checkbox"/> 28 Day Starter Pack <input type="checkbox"/> Maintenance <input type="checkbox"/> Bridge Dose Pack	<input type="checkbox"/> Take as directed per package instructions (Quantity: 55) <input type="checkbox"/> 14 day titration starter pack sample provided by MD office <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 60) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 30) Continuation of Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Take 30 mg PO twice daily (Quantity: 28) (12 refills) <input type="checkbox"/> Take 30 mg PO once daily (Quantity: 28) (6 refills)		
Siliq™ <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 210 mg SQ on weeks 0 & 1 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 210 mg SQ every 2 weeks starting at week 2 (Quantity: 2)		
Skyrizi™ <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> INITIAL: Inject 150 mg (two 75 mg injections) SQ on weeks 0, 4, and every 12 weeks thereafter. <input type="checkbox"/> Physician administered <input type="checkbox"/> Patient administered		
Stelara® <input type="checkbox"/> 45 mg Vial (Pediatric ≤ 60 kg) <input type="checkbox"/> Pre-filled Syringe <input type="checkbox"/> 45 mg <input type="checkbox"/> 90 mg Weight Required: _____	<input type="checkbox"/> INITIAL: Inject SQ on day 0 and day 28 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject SQ every 12 weeks (Quantity:1)	***WEIGHT BASED GUIDELINES*** PEDIATRIC: Less than 60 kg (132.2 lbs): 0.75 mg/kg 60 kg-100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90 mg ADULT: Less than or equal to 100 kg (220 lbs): 45 mg Greater than 100 kg (220 lbs): 90 mg	
Taltz® 80 mg <input type="checkbox"/> CE <input type="checkbox"/> 4 <input type="checkbox"/> 8 <input type="checkbox"/> 16 <input type="checkbox"/> PFS	<input type="checkbox"/> LOAD: For Uveitis, AIA, or Psoriatic arthritis: 160 mg (as two 80mg injections) subcutaneously on week 0, then 80 mg on week 2, then Inject 80 mg subcutaneously every 2 weeks (weeks 2-12) <input type="checkbox"/> MAINTENANCE: Inject 80mg subcutaneously every 4 weeks.		
Tremfya™ 100 mg <input type="checkbox"/> One-press <input type="checkbox"/> PFS Injector	<input type="checkbox"/> INITIAL: 100mg subcutaneously on weeks 0 and 4 (Quantity: 2) <input type="checkbox"/> MAINTENANCE: Inject 100mg subcutaneously every 8 weeks thereafter (Quantity: 1)		

MEDICAL INFORMATION				
PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY				
Previous Therapies: <input type="checkbox"/> Methotrexate <input type="checkbox"/> Soriatane <input type="checkbox"/> Clobetasol <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Eucrisa <input type="checkbox"/> Stelara <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel <input type="checkbox"/> _____	Tried & Failed (Duration): <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____) <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contraindication: _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Face <input type="checkbox"/> Feet <input type="checkbox"/> Groin <input type="checkbox"/> Hands <input type="checkbox"/> Nails <input type="checkbox"/> Scalp <input type="checkbox"/> Other: _____ 
PHOTOTHERAPY <input type="checkbox"/> UVA/UVB <input type="checkbox"/> Patient Cannot Afford	Tried & Failed (Duration): <input type="checkbox"/> (_____)	Not Tolerated: <input type="checkbox"/> Photosensitivity <input type="checkbox"/> Risk of skin cancer	Contraindication: <input type="checkbox"/> Distance from office	Scoring Tool Used: <input type="checkbox"/> BSI <input type="checkbox"/> EASI <input type="checkbox"/> SCORAD <input type="checkbox"/> POEM <input type="checkbox"/> ISGA <input type="checkbox"/> % or SCORE _____
<input type="checkbox"/> L40.Psoriasis Vulgaris (Plaque Psoriasis) <input type="checkbox"/> Other: _____				Date of Diagnosis: _____ <input type="checkbox"/> Active TB is ruled out: Date: _____ <input type="checkbox"/> Hep B ruled out/treated: Date: _____
Additional Clinical Information: _____				

AMERICAN ACADEMY OF DERMATOLOGY CONSENSUS STATEMENT ON PSORIASIS THERAPIES				
<input type="checkbox"/> Psoriasis is covering greater than 10% body surface area	<input type="checkbox"/> Psoriasis is on palms, soles, head & neck, or genitals	<input type="checkbox"/> Psoriasis occurs in conjunction with pain, swelling, or stiffness in joints	<input type="checkbox"/> Psoriasis patient needs more aggressive therapy due to impact on ability to perform daily activities, employment, or interpersonal relationships	

INJECTION TRAINING		
<input type="checkbox"/> Patient has received pen and injection training	<input type="checkbox"/> Physician's office to provide injection training	<input type="checkbox"/> 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: _____