Gastrointestinal Enrollment Form: I-Z

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

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Louisiana Office
2400 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:	SSN#:			Prescribing Practitioner:		NPI:	
Address:				Address:			
City:	State/Zip:			City		State/Zip	
Telephone:	DOB:	M ☐ F ☐		Office:		DEA:	
Language Preference:	Wt:	Ht:		Contact:	Phone:	Fax:	

PRESCRIPTION

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

Drug		Directions and Quantity	Refills
Remicade®	☐ Vials	☐ **INITIAL:** Infuse _____ mg IV on day 0, 14, and 42 (Quantity: _____) ☐ **MAINTENANCE:** Infuse _____ mg IV every 8 weeks (Quantity: _____)	
	☐ Vials	☐ **INITIAL:** Intravenous induction regimen of 5mg/kg given at 0, 2, and 6 weeks ☐ **MAINTENANCE:** Intravenous induction regimen of 5mg/kg every 8 weeks thereafter	
Simponi®	☐ 100 mg Smartject® Pen ☐ 100 mg Pre-filled Syringe	☐ **INITIAL:** Inject 200 mg SQ on day 0, then 100 mg on day 14 (Quantity: 3) ☐ **MAINTENANCE:** Infject 100 mg SQ every 4 weeks (Quantity: 1)	
Stelara®	☐ 130 mg/26 mL Vials ☐ Pre-filled Syringe **Weight Required:** _____ ☐ 45 mg/0.5 mL Vials ☐ 90 mg/mL Vial	☐ **INITIAL INTRAVENOUS DOSAGE:** A single intravenous infusion using weight based dosing: Up to 55g=260mg (2 vials), >55g to 85kg=390 mg (3 vials), >85kg=520 mg (4 vials) ☐ **MAINTENANCE:** Inject 90 mg SQ 8 weeks after intial dose, then every 8 weeks thereafter (1 syringe) **SUBCUTANEOUS DOSAGE:** ☐ **≤ 100 kg:** 45 mg subQ initially and then 4 weeks later, ☐ 45 mg subQ every 12 weeks after ☐ **>100 kg:** 90 mg subQ initially and then 4 weeks later, ☐ 90 mg subQ every 12 weeks after	
Xeljanz®	☐ 10 mg Tablets	☐ **INITIAL:** Take 10 mg PO twice daily (Quantity: 60 with 1 refill)	
	☐ 5 mg Tablets ☐ 10 mg Tablets	☐ **MAINTENANCE:** Take 5 mg PO twice daily (Quantity: 60) ☐ **MAINTENANCE:** Take 10 mg PO twice daily (Quantity: 60)	

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	☐ (_____)	☐	_____
☐ Sulfasalazine	☐ (_____)	☐	_____
☐ Pentasa	☐ (_____)	☐	_____
☐ Entocort	☐ (_____)	☐	_____
☐ Cimzia	☐ (_____)	☐	_____
☐ Humira	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____
☐ _____	☐ (_____)	☐	_____

Allergies:

☐ K50.00 Crohn's disease of small intestine, without complications
☐ K50.10 Crohn's disease of large intestine, without complications
☐ K50.80 Crohn's disease of both intestines, without complications
☐ K50.90 Crohn's disease unspecified, without complications
☐ K51.50 Left-sided Ulcerative Colitis, without complications
☐ K51.80 Other Ulcerative Colitis, without complications
☐ K51.90 Ulcerative Colitis unspecified, without complications
☐ Other: _____

Date of Diagnosis: _____/_____/_____ Active TB is ruled out: ☐ Hep B Ruled out/treated: ☐

Date of Diagnosis: _____/_____/_____ **Date of Diagnosis:** _____/_____/_____

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:**

CONFIDENTIALITY NOTICE