Rheumatology Enrollment Form: I-Z

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

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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 #:	New ☐ Refill ☐	Ship by:

PRESCRIPTION

Drug		Directions	Quantity	Refills
Kevzara®	☐ Pen ☐ 150 mg ☐ 200 mg ☐ Pre-filled Syringe ☐ 150 mg ☐ 200 mg	☐ Inject 150 mg SQ every 2 weeks (Quantity: 2) ☐ Inject 200 mg SQ every 2 weeks (Quantity: 2)		
Olumiant®	☐ 2 mg Tablets	☐ Take 2 mg PO once daily (Quantity 30)		
Orencia®	☐ Vials ☐ Pre-filled Syringe ☐ ClickJect™	☐ **INITIAL:** Infuse _____ mg via (IV) intravenous on week 0, 2, and 4 (Quantity: ____) ☐ **MAINTENANCE:** Infuse ____ mg via (IV) intravenous every 4 weeks (Quantity: ____) ☐ Inject 125 mg (SQ) subcutaneous once weekly (Quantity: 4)		
Prolia®	☐ 60mg	☐ Inject 60mg subq every 6 months	1 month supply	
Simponi®	☐ SmartJect® (Pen) ☐ Pre-filled Syringe	☐ Inject 50 mg SQ once a month. (Quantity: 1)		
Simponi Aria®	☐ 50 mg Vial Weight required: _____	☐ **INITIAL:** Infuse 2 mg/kg via IV over 30 minutes at weeks 0 and 4 (Quantity: QS doses) ☐ **MAINTENANCE:** Infuse 2 mg/kg via IV over 30 minutes every 8 weeks thereafter (Quantity: QS 1 dose)		
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 SQ initially and then 4 weeks later, ☐ 45 mg SQ every 12 weeks after ☐ **>100 kg:** 90 mg SQ initially and then 4 weeks later. ☐ 90 mg SQ every 12 weeks after ☐ Inject 300 mg SQ week 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks. Each 300 dosage is given as 2 150 mg injections		
Xeljanz®	☐ 5 mg Tablets	☐ Take 5 mg PO twice daily (Quantity: 60)		
Xeljanz® XR	☐ 11 mg Tablets	☐ Take 11 mg PO once daily (Quantity: 30)		

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

☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.00 Rheumatoid Arthritis without Rheumatoid Factor, Unspecified
☐ M08.00 Unspecified Juvenile Rheumatoid Arthritis of Unspecified Site
☐ M05.9 Rheumatoid Arthritis, with Rheumatoid Factor, Unspecified
☐ M45.9 Ankylosing Spondylitis, Unspecified
☐ Other: _____

Additional Clinical Info:

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

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

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: