Rheumatology Infusion Enrollment Form

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

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 #:		

PRESCRIPTION

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

Drug		Directions	Quantity	Refills
Actemra®		Infuse: ☐ 80mg ☐ 200mg ☐ 400mg every 4 weeks	1 month supply	
Benlysta®	☐ 120mg/vial ☐ 400mg/vial	☐ Loading Dose: Infuse _____ mg at weeks 0,2, and 4 ☐ Maintenance Dose: Infuse _____ mg every 4 weeks	4 week supply	
Boniva®	☐ 3mg/ml	☐ Inject 3 mg every 3 months	1 month supply	
Cimzia®	☐ 200mg/vial	☐ Infuse: _____	1 month supply	
Krystexxa®	☐ 8mg/vial	☐ Infuse: _____	1 month supply	
Orencia®	☐ 250mg vial	☐ Infuse: _____	1 month supply	
Prolia®	☐ 60mg	☐ Inject 60mg subq every 6 months	1 month supply	
Reclast®	☐ 5mg/100ml	☐ Infuse: _____	1 month supply	
Remicade®	☐ 100mg vial	☐ Infuse: _____	1 month supply	
Rituxan®	☐ 100mg vial ☐ 500mg vial	☐ Infuse: _____	1 month supply	
Simponi Aria®	☐ 50mg/4ml	☐ Infuse: _____	1 month supply	
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 ☐ Inject 300 mg subQ week 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks. Each 300 dosage is given as 2 150 mg injections		

DIAGNOSIS AND CLINICAL INFORMATION

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

☐ M06.9 Rheumatoid Arthritis ☐ L40.52 Psoratic Arthritis
☐ M45.9 Ankylosing Spondylitis
☐ M32.10 Systemic Lupus Erythematosus
☐ K50.00 Crohn's Disease
☐ Other: _____

TB/PPD test: ☐ Positive ☐ Negative Date Read: _____

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Lab Data: _____

Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

Additional Clinical Information:

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:**