Endocrinology Enrollment Form

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

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

PLEASE FAX COPY OF: PRESCRIPTION FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

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: | Ship to: Patient's Home Doctor's Office Other:______________________

Drug	Strength	Directions	Quantity	Refills
Forteo®	600mcg/2.4mL	Inject 20mcg SubQ daily	1 month supply	
Praluent®	75mg PFS 75mg Pen 150mg PFS 150mgPen	Inject 75mg SubQ once every 2 weeks Inject 150mg SubQ once every 2 weeks	1 month supply	
Prolia®	60mg	Inject 60mg SubQ every 6 months	1 month supply	
Reclast®	5mg/100mL	Infuse 5mg once yearly	1 vial	
Repatha®	140mg/mL Sureclick	Inject 140mg every 2 weeks into abdomen, thigh, or upper arm Inject 420mg once monthly into abdomen, thigh, or upper arm (Give 3 injections within 30 minutes)	1 month supply	
Thyrogen®	2 vial kit	Inject 0.9mg IM day 1 followed by 0.9 IM day 2	1 kit	
Other:				

DIAGNOSIS AND CLINICAL INFORMATION

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

E78.0 Pure Hypercholesterolemia (including HeFH and HoFH)
E78.2 Mixed Hyperlipidemia
E78.4 Other and Unspecified Hyperlipidemia
Other: ____

Prior Medication Failed: ____
Length of Treatment:____
Reason for Discontinuation: ____
Forteo® Home Health Training Required

LDL-C Treatment: Atovastatin Rosuvastatin Simvastatin Ezetimibe Other
Dose: ______________

Allergies:

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: