Fax:

Phone:

Oncology Enrollment Form

PATIENT INFORMATION *Please complete the following or* ***send patient demographic sheet***

Patient Name ______ DOB ______ Last Four of SS# ______ Gender ______

Address ______ City, State, ZIP ______

Home Phone ______ Alternate Phone ______ Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

NPI ______ DEA ______

Group/Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

Prescriber's Name ______

NPI ______ Office Contact ______

Prescriber's Name ______

NPI ______ Office Contact ______

Prescriber's Name ______

NPI ______ Office Contact ______

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ______

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis — *Please include diagnosis name with ICD-10 code*

☐ ICD-10 ______ Description ______

Test Results: **WNL:**

☐ SCr/CrCl ______ ☐ Yes ☐ No

☐ LFTs ______ ☐ Yes ☐ No

☐ Hgb/Hct ______ ☐ Yes ☐ No

☐ WBC ______ ☐ Yes ☐ No

☐ Electrolytes ______ ☐ Yes ☐ No

☐ CT/MRI/Other ______ ☐ Yes ☐ No

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ______ kg/lbs Height ______ cm/in BSA ______ m^2

Allergies ______

Prior Therapies ______

Concomitant Medications ______

Additional Comments ______

Current Cycle # ______ Total # of Cycles ______

PRESCRIPTION INFORMATION

Medication

☐ Afinitor®	☐ Alecensa®	☐ Alkeran®	☐ Alunbrig™	☐ Bosulif®	☐ Cabometyx®	☐ Cotellic™	☐ Cyclophosphamide	☐ Erivedge®
☐ Erleada™	☐ Etoposide	☐ Exjade™	☐ Fareston®	☐ Farydak®	☐ Gleevec®	☐ Gleostine®	☐ Hycamtin®	☐ Ibrance®
☐ Inlyta®	☐ Jakafi®	☐ Kisqali® & Femara	☐ Kisqali®	☐ Leukeran®	☐ Mekinist®	☐ Nexavar®	☐ Nilandron®	☐ Ninlaro®
☐ Odomzo®	☐ Opdivo®	☐ Purixan®	☐ Rydapt®	☐ Sprycel®	☐ Stivarga®	☐ Sutent®	☐ Tabloid®	☐ Tafinlar®
☐ Talzenna®	☐ Tarceva®	☐ Targretin®	☐ Tasigna®	☐ Temodar®	☐ Tretinoin	☐ Tykerb®	☐ Verzenio®	☐ Vizimpro®
☐ Votrient®	☐ Xalkori®	☐ Xeloda®	☐ Xtandi®	☐ Yonsa®	☐ Zelboraf®	☐ Zolinza®	☐ Zykadia™	☐ Zytiga®

☐ Other ______

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

☐ Infusable ______

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

******Prescriber Authorization:*** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to: ☐ Patient ☐ Office ☐ Other ______ Date ______ Needs by Date ______

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______ Date ______

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.