Oncology – Revlimid, Pomalyst, Thalomid Enrollment Form

Specialty Pharmacy Enrollment Form Please detach before submitting to a pharmacy – tear here.

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 ________

☐ Pomalyst® Physician Authorization # ____________ Diagnosis: ☐ MMC90.00 ☐ Date ________

☐ Revlimid® Physician Authorization # ____________ Diagnosis: ☐ MDS D45.9 ☐ MMC90.00 ☐ Date ________

☐ Thalomid® Physician Authorization # ____________ Diagnosis: ☐ MMC90.00 ☐ Date ________

Pregnancy Category: ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Female – Reproductive Potential ☐ Adult Male ☐ Female Child – NOT of Reproductive Potential ☐ Female Child – Reproductive Potential ☐ Male Child

PRESCRIPTION INFORMATION

Medication				
	Dose/Strength	**Directions**	**Therapy Cycle**	**Quantity**
☐ Revlimid				
☐ Pomalyst				
☐ Thalomid				

****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: ________ Supervising Physician Signature: ____________ Date: ________

Electronic or digital signatures not accepted.

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