

Oncology Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION Deliver Here
 (Complete the following or include demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Primary Phone: _____ DOB: _____
 Alternate Phone: _____ Gender: Male Female
 Email address: _____
 Last 4 digits SS#: _____

PRESCRIBER INFORMATION Deliver Here

Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____
 Address: _____
 City, State Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Primary Diagnosis: _____ ICD-10 Code: _____ Date of Diagnosis: _____

**Please include Dx Code # and description Prior Failed Meds: _____

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

Name	Strength	Directions	QUANTITY	REFILLS
<input type="checkbox"/> AFINITOR				
<input type="checkbox"/> GLEEVEC				
<input type="checkbox"/> MEKINIST/TAFLINAR				
<input type="checkbox"/> SPRYCEL				
<input type="checkbox"/> SUTENT				
<input type="checkbox"/> TARCEVA				
<input type="checkbox"/> TASIGNA				
<input type="checkbox"/> TEMODAR				
<input type="checkbox"/> VOTRIENT				
<input type="checkbox"/> XELODA				
<input type="checkbox"/> ZYTIGA				
<input type="checkbox"/> OTHER				
ANTIEMETICS				
<input type="checkbox"/> Compazine				
<input type="checkbox"/> Emend Tri-fold		Take 1 capsule (125mg) by mouth on day 1, and take 1 capsule (80mg) by mouth on day 2 and day 3 of chemo cycle	Chemo cycle frequency: _____ days	
<input type="checkbox"/> Reglan				
<input type="checkbox"/> Sancuso Patch				
<input type="checkbox"/> Other				

PRESCRIPTION

PHYSICIAN SIGNATURE

To Physician: By signing this form and utilizing our services, you are also authorizing pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Physician Signature: _____

Date: _____

CONFIDENTIALITY NOTICE

IMPORTANT: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.