Oncology Enrollment Form

Fax: 909-284-9140
Phone: 909-266-0016
□ **Urgent Request**
Rep: _____

PATIENT INFORMATION

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

Patient Name _____
Address _____
Address 2 _____
City, State, Zip _____
Home Phone _____ Mobile Phone _____
DOB _____Last Four of SS _____ Gender _____
Language Preference _____

PRESCRIBER INFORMATION

Prescriber Name _____
DEA _____
NPI _____
Address _____
City, State, Zip _____
Phone _____Fax _____
Contact Person _____

Clinical Diagnosis: please fax or email relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization

Diagnosis / ICD 10:

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
□ Abraxane	□ 100 mg/50 ml			
□ Adcetris	□ 50 mg vial			
□ Albumin	□ 25% 50 ml □ 25% 100 ml			
□ Alimta	□ 100 mg/4 ml □ 500 mg/20 ml			
□ Avastin	□ 100 mg/4 ml			
□ Camptosar	□ 20 mg/1 ml 2 ml vial			
□ Carboplatin	□ 10 mg/1 ml 5 ml vial □ 10 mg/1 ml 15 ml vial			
□ Cytarabine	□ 100 mg/ml 20 ml vial			
□ Docetaxel	□ 20 mg/ml 1 ml vial			
□ Doxirubicin	□ 10 mg SDV			
□ Doxirubicin Lip	□ 20 mg/10 ml			
□ Doxirubicin Lipo	□ 2 mg/ ml 20ml			
□ Epirubic	□ 2 mg/ ml 25 ml			
□ Etoposide	□ 100 mg 5 ml □ 500 mg			
□ Floxuridine	□ 500 mg 6 ml			
□ Fluorouracil	□ 500 mg/ 10 ml SDV			
□ Gemcitabine Lyo	□ 200 mg SDV			
□ Halaven	□ 1 gram			
□ Ifosfamide	□ 50 mg/ml 20 ml SDV			
□ Irinotecan	□ 20 mg/ ml 5 ml vial			
□ Keytruda	□ 100 mg			
□ Melphalan Lyo	□ 50 mg vial			
□ Methotrexate	□ 25 mg/ ml 2 ml			
□ Mitomycin	□ 20mg vial			
□ Oxaliplatin	□ 100mg 10 ml vial			
□ Paclitaxel	□ 100mg/ ml 16.7 ml			
□ Rituxan	□ 500 mg 50 ml			
□ Topotecan	□ 4 mg			
□ Vincristine	□ 2 mg/2 ml vial			
□ Vinorelbine	□ 10 mg/ml 1 ml □ 10 mg/ml 5 ml			
□ Zarxio	□ 300 mcg/0.5 ml			
□ Other				

Ship to: □ Patient □ Office □ Other _____ Date: _____ Need by Date _____

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 authorizations forms and the receipt and submission of patient tab values and other patient data, in the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize the 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.

□ Product Substitution permitted □ Dispense as Written

Prescriber's Signature: _____ Date: _____