



# 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
<input type="checkbox"/> Abraxane	<input type="checkbox"/> 100 mg/50 ml			
<input type="checkbox"/> Adcetris	<input type="checkbox"/> 50 mg vial			
<input type="checkbox"/> Albumin	<input type="checkbox"/> 25% 50 ml <input type="checkbox"/> 25% 100 ml			
<input type="checkbox"/> Alimta	<input type="checkbox"/> 100 mg/4 ml <input type="checkbox"/> 500 mg/20 ml			
<input type="checkbox"/> Avastin	<input type="checkbox"/> 100 mg/4 ml			
<input type="checkbox"/> Camptosar	<input type="checkbox"/> 20 mg/1 ml 2 ml vial			
<input type="checkbox"/> Carboplatin	<input type="checkbox"/> 10 mg/1 ml 5 ml vial <input type="checkbox"/> 10 mg/1 ml 15 ml vial			
<input type="checkbox"/> Cytarabine	<input type="checkbox"/> 100 mg/ml 20 ml vial			
<input type="checkbox"/> Docetaxel	<input type="checkbox"/> 20 mg/ml 1 ml vial			
<input type="checkbox"/> Doxorubicin	<input type="checkbox"/> 10 mg SDV			
<input type="checkbox"/> Doxorubicin Lip	<input type="checkbox"/> 20 mg/10 ml			
<input type="checkbox"/> Doxorubicin Lipo	<input type="checkbox"/> 2 mg/ ml 20ml			
<input type="checkbox"/> Epirubic	<input type="checkbox"/> 2 mg/ ml 25 ml			
<input type="checkbox"/> Etoposide	<input type="checkbox"/> 100 mg 5 ml <input type="checkbox"/> 500 mg			
<input type="checkbox"/> Floxuridine	<input type="checkbox"/> 500 mg 6 ml			
<input type="checkbox"/> Fluorouracil	<input type="checkbox"/> 500 mg/ 10 ml SDV			
<input type="checkbox"/> Gemcitabine Lyo	<input type="checkbox"/> 200 mg SDV			
<input type="checkbox"/> Halaven	<input type="checkbox"/> 1 gram			
<input type="checkbox"/> Ifosfamide	<input type="checkbox"/> 50 mg/ml 20 ml SDV			
<input type="checkbox"/> Irinotecan	<input type="checkbox"/> 20 mg/ ml 5 ml vial			
<input type="checkbox"/> Keytruda	<input type="checkbox"/> 100 mg			
<input type="checkbox"/> Melphalan Lyo	<input type="checkbox"/> 50 mg vial			
<input type="checkbox"/> Methotrexate	<input type="checkbox"/> 25 mg/ ml 2 ml			
<input type="checkbox"/> Mitomycin	<input type="checkbox"/> 20mg vial			
<input type="checkbox"/> Oxaliplatin	<input type="checkbox"/> 100mg 10 ml vial			
<input type="checkbox"/> Paclitaxel	<input type="checkbox"/> 100mg/ ml 16.7 ml			
<input type="checkbox"/> Rituxan	<input type="checkbox"/> 500 mg 50 ml			
<input type="checkbox"/> Topotecan	<input type="checkbox"/> 4 mg			
<input type="checkbox"/> Vincristine	<input type="checkbox"/> 2 mg/2 ml vial			
<input type="checkbox"/> Vinorelbine	<input type="checkbox"/> 10 mg/ml 1 ml <input type="checkbox"/> 10 mg/ml 5 ml			
<input type="checkbox"/> Zarxio	<input type="checkbox"/> 300 mcg/0.5 ml			
<input type="checkbox"/> 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: \_\_\_\_\_

**CONFIDENTIALITY STATEMENT:** This communication is intended for 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.