



Oncology Enrollment Form

Fax: 949-340-8008

Phone: 949-305-0788

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: _____

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