



Oncology Phone: 877-445-6874
 Fax: 877-342-4596

Oncology Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____
 Address _____
 Address 2 _____
 City, State, ZIP _____
 Home Phone _____ Alternate Phone _____
 DOB _____ Last Four of SS# _____ Gender _____
 Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____
 NPI _____
 Group/Hospital _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number _____ (if known) PA approved until: _____

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:
 SCr/CrCl _____ Yes No
 LFTs _____ Yes No
 Hgb/Hct _____ Yes No
 WBC _____ Yes No
 Electrolytes _____ Yes No
 CT/MRI/Other _____ Yes No

WNL:

Additional Information Therapy: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m²
 Allergies _____
 Prior Therapies _____
 Concomitant Medications _____
 Additional Comments _____
 Current Cycle # _____ Total # of Cycles _____

PRESCRIPTION INFORMATION

Medication

- | | | | | | |
|--|--|--|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Abiraterone | <input type="checkbox"/> Deferasirox tablet for suspension | <input type="checkbox"/> Imatinib | <input type="checkbox"/> Ninlaro® | <input type="checkbox"/> Tabloid® | <input type="checkbox"/> Vizimpro® |
| <input type="checkbox"/> Alecensa® | <input type="checkbox"/> Deferasirox film coated tablet | <input type="checkbox"/> Inlyta® | <input type="checkbox"/> Nubeqa™ | <input type="checkbox"/> Tabrecta™ | <input type="checkbox"/> Votrient® |
| <input type="checkbox"/> Alunbrig™ | <input type="checkbox"/> Erivedge® | <input type="checkbox"/> Inrebic® | <input type="checkbox"/> Odomzo® | <input type="checkbox"/> Tafinlar® | <input type="checkbox"/> Xalkori® |
| <input type="checkbox"/> Bexarotene capsules | <input type="checkbox"/> Erleada™ | <input type="checkbox"/> Jakafi® | <input type="checkbox"/> Opdivo® | <input type="checkbox"/> Talzenna® | <input type="checkbox"/> Xtandi® |
| <input type="checkbox"/> Bosulif® | <input type="checkbox"/> Erlotinib | <input type="checkbox"/> Kisqali® & Femara | <input type="checkbox"/> Purixan™ | <input type="checkbox"/> Targretin® gel | <input type="checkbox"/> Yonsa® |
| <input type="checkbox"/> Cabometyx® | <input type="checkbox"/> Etoposide | <input type="checkbox"/> Kisqali® | <input type="checkbox"/> Retevmo™ | <input type="checkbox"/> Tasigna® | <input type="checkbox"/> Zelboraf® |
| <input type="checkbox"/> Capecitabine | <input type="checkbox"/> Everolimus | <input type="checkbox"/> Leukeran® | <input type="checkbox"/> Rozlytrek® | <input type="checkbox"/> Temozolomide | <input type="checkbox"/> Zolanza® |
| <input type="checkbox"/> Cotellix™ | <input type="checkbox"/> Farydak® | <input type="checkbox"/> Mekinist® | <input type="checkbox"/> Rydapt® | <input type="checkbox"/> Toremifene | <input type="checkbox"/> Zykadia™ |
| <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> Gleostine® | <input type="checkbox"/> Melphalan | <input type="checkbox"/> Sprycel® | <input type="checkbox"/> Tretinoin | |
| | <input type="checkbox"/> Hycamtin® | <input type="checkbox"/> Nexavar® | <input type="checkbox"/> Stivarga® | <input type="checkbox"/> Tykerb® | |
| | <input type="checkbox"/> Ibrance® | <input type="checkbox"/> Nilandron® | <input type="checkbox"/> Sutent® | <input type="checkbox"/> Verzenio® | |

Dose/Strength

Directions

Therapy Cycle

Quantity

Refills

Infusable _____

Dose/Strength

Directions

Therapy Cycle

Quantity

Refills

Ship to: Patient Office Other _____ Date _____ Needs 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 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.

Prescriber's Signature _____ Date _____ Supervising Physician Signature _____ Date _____

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the 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. This form is not a valid prescription in Arizona.