ONCOLOGY ENROLLMENT FORM

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Social Security No ______________________ Date of Birth ______________________

Sex □ M □ F Weight_______ Height________ Allergies______________________

Home Phone ______________________ Work/Mobile ______________________

Home Address ______________________

City __________ State __________ Zip __________

PATIENT INSURANCE INFORMATION

Primary Medical Insurance ______________________ Medical Insurance Phone ______________________

Subscriber Name ______________________

Rx Card (PBM) ______________________ Group No ______________________

Prescription Card Bin # :___________________ PCN #:______________________

TREATMENT ARRANGEMENTS

•Start Date:______________________ Ship Meds □ Home □ Doctor's Office

Teaching by: □ Doctor's Office □ Other:______________________________

STATEMENT OD MEDICAL NECESSITY

Diagnosis Description: □ ________________________________ Diagnosis (ICD-10 Code): __________________________ Date Of Diagnosis: ____________________

Diagnosis Description: □ ________________________________ Diagnosis (ICD-10 Code): __________________________ Date Of Diagnosis: ____________________

Other Clinical information\ Comments:

Weight: _______________ □ Kg □ lbs □ Height: ____________________ □ Inches □ Cm BSA: __________________ m2

Other Conditions: ____

Other Medications: ____

Allergies: ____ □ **NKDA**

Previous therapies: ____

Test Result:	**WNL**		**WNL**
Serum Creatinine: _________________________	□ **Yes** □ **No**	Magnesium: ______________________	□ **Yes** □ **No**
Liver Function: ___________________________	□ **Yes** □ **No**	ECG: ___________________________	□ **Yes** □ **No**
Potassium: _______________________________	□ **Yes** □ **No**	Baseline BP: ______________________	□ **Yes** □ **No**

□ **Revlimid®-RevAssist** Physician Auth#: ___________________________ Date: ____________________ Revlimid Diagnosis: □ **MDS 238.7**

□ **Thalomid®-STEPS Program** Physician Auth#: ___________________________ Date: ____________________ Thalomid Diagnosis: □ **MM 203.0**

Pregnancy Category:

□ Adult female - Childbearing Potential □ Adult Female - NOT of Childbearing Potential □ **Adult Male**

□ Female Child - Childbearing Potential □ Female Child - NOT of Childbearing Potential □ **Male Child**

PRESCRIPTION INFORMATION

□ **Afinitor® (everolimus)**	□ **Gleevec® (imatinib mesylate)**	□ **Hycamtin® (topotecan)**	□ **Velcade® (bortezomib)**
□ **Oforta® (fludarabine)**	□ **Tafinlar® (debrafinib)**	□ **Sprycel® (dasatinib)**	□ **Avastin® (bevacizumab)**
□ **Mekinist® (trametinib)**	□ **Targretin® (bexarotene)**	□ **Tasigna® (nilotinib)**	□ **Temodar® (temozolomide)**
□ **Zytiga® (abiraterone)**	□ **Tykerb® (lapatinib)**	□ **Votrient® (pazopanib)**	□ **Xeloda® (capecitabine)**
□ **Zolinza® (vorinostat)**	□ **Promacta® (eltrombopag)**	□ **Halaven® (eribulin)**	□ **Opdivo® (nivolumab)**
□ **Keytruda® (pembrolizumab)**	□ **Lonsurf® (trifluride & tipiracil)**	□ **Carboplatin**	□ **Cisplatin**
□ **Taxol**	□ **Taxotere**	□ **Adriamycin**	□ **Doxil**
□ **Cytoxan**	□ **Methotrexate**	□ **Gemcitabine**	□ **Etoposide**

STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□	□		

□ ***Skilled Nursing Visit for self injection training one injection visit with next dose id needed.***

Physician Signature:____ □ **DAW (Dispense as written Date:** ______________________

Physician Name:__________________________ **Phone: #** ______________________ **Fax: #** ______________________**Office Contact**____________

Physician Address:____ **NPI:**________________________ **DEA #**____________________

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