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 #**_____

FAX TO 747-900-8489

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