ONCOLOGY ENROLLMENT FORM

Patient Information

Phone:
Fax:
Toll Free:

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed:________________ Rx: ☐ New ☐ Refill ________________

Patient Information

Date:______________ Patient SS#: ____________________ Diagnosis Description: _______________ ICD9 Code:__________

☐ Adult Male ☐ Child Male ☐ Adult Female Not of Reproductive Potential ☐ Adult Female of Reproductive Potential

☐ Female Child Not of Reproductive Potential ☐ Female Child of Reproductive Potential

Patient's First Name:___________________________________ Patient's Last Name:_____________________________________

Address:____City/County: _____________________ State:_____ Zip: __________

Home Phone: ________________________ Work Phone: ________________________ Cell Phone:________________________

DOB:_______________________ Patient's Weight:_________ lbs. Recorded Date: ______________________________

Allergies: ____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (BOTH FRONT & BACK)

IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: ____

Prescription

ORAL ONCOLYTICS

☐ Afinitor	☐ Gleevec	☐ Pomalyst**	☐ Tamoxifen	☐ Xeloda
☐ Arimidex	☐ Hycamtin	☐ Revlimid**	☐ Tarceva	☐ Xtandi
☐ Bosulif	☐ Iclusig	☐ Sprycel	☐ Tasigna	☐ Zolinza
☐ Cometriq	☐ Inlyta	☐ Sutent	☐ Temodar	☐ _________
☐ Erivedge	☐ Jakafi	☐ Stivarga	☐ Thalomid**	
* Exjade	☐ Mekinist	☐ Sylatron	☐ Tykerb	
☐ Femara	☐ Nexavar	☐ Tafinlar	☐ Votrient	

QTY:

DOSING & SIG:

Refill #: ________________________

**Authorization #: ____________________

☐ Zelboraf BRAF V600E mutation positive as detected by an FDA-approved test? ☐ Yes ☐ No

☐ Zytiga Qty: _______ 250mg 4 QD w/o food Zytiga Refill #: ____________________________

☐ WITH Prednisone Qty: _______ 5mg BID w/ food Prednisone Refill #: _________________________

* EXJADE Rxs (Fax ALL EPASS forms to 813.549.3810)

SUPPORT DRUGS

☐ Aranesp	☐ Arixtra	☐ Caphosol	☐ Emend	☐ Lovenox	☐ Neulasta
☐ Neupogen	☐ Nplate*	☐ Procrit	☐ Promacta	☐ Sancuso	☐ Zofran

*Call for ordering procedure

QTY:

DOSING & SIG:

Refill #: ________________________

Complete this section ONLY if you would like Superior Specialty Pharmacy to initiate a Prior Authorization or Appeal on your behalf:

Previous Therapies

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression	________________
	☐ Finished Therapy	________________
	☐ Toxicity: ______________________________	________________

Prescriber Information

Physician: ____

____

Contact Name: ___________________ Phone #: __________________ Fax #: __________________ NPI #: ______________

Office Address: ____ City: _________________ State: _____ Zip:________

I authorize and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature: ____ DEA #:____________________ Date: _____________