Oral Oncology Enrollment Form

PATIENT INFORMATION

Patient Name: ____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: ____
City: _____________ State: _____ Zip: _______________

Phone: (____) - ____ - ________
email: ______________________________________
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: _________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

PRESCRIBER INFORMATION

Prescriber Name: ____________________________________
Address: ____
City: _____________ State: _____ Zip: _______________
Contact: __________________________
Clinic/Hospital Affiliation: ______________________________

Phone: (____) - ____ - ________
Fax: (____) - ____ - ________
License #: __________________________
NPI #: __________________________
Medicaid Provider #: __________________________

OONCRX-17-01

CLINICAL CONSIDERATIONS

ICD10: _____________________
Diagnosis:

Past Medical History:

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

☐ New Therapy ☐ Current Therapy (Start date: ____ /____ / ____)

Medication

☐ **Afinitor**®
☐ **Bosulif**®
☐ **Erivedge**™
☐ **Fareston**®
☐ **Gleevec**®
☐ **Hycamtin**®
☐ **Iclusig**™
☐ **Imbruvica**®
☐ **Inlyta**®
☐ **Jakafi**™
☐ **KISQALI**®
☐ **Pomalyst**®
☐ **Revlimid**®
☐ **Thalomid**®
☐ **Lonsurf**®
☐ **Mekinist**™
☐ **Mozibil**®
☐ **Nexavar**®
☐ **Sprycel**®
☐ **Stivarga**®
☐ **Sutent**®
☐ **Tafinlar**™
☐ **Tarceva**™
☐ **Targretin**®
☐ **Tasigna**®
☐ **Temodar**®
☐ **Tykerb** ®
☐ **Votrient**™
☐ **Xalkori**®
☐ **Xeloda**®
☐ **Xtandi**®
☐ **Zelboraf**™
☐ **Zolinza**®
☐ **Zydelig**™
☐ **Zytiga**™

REMS MD Auth #: _______________ Date: ___________
REMS MD Auth #: _______________ Date: ___________
REMS MD Auth #: _______________ Date: ___________

Directions / Dispense Quantity / Refills

____
____
____
____
____
____
____
____
____
____
____

Steroidal Therapy: ☐ Prednisone ☐ Dexamethasone Directions: ______________________ Qty: _____ Refills: _____

Antiemetic Therapy: __________________________ Directions: ______________________ Qty: _____ Refills: _____

Date of last dose ____ /____ / ____ Expected date of first/next dose ____ /____ / ____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

PANTHERx SPECIALTY PHARMACY **PHONE**: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherspecialty.com**