

ONCOLOGY SPECIALTY CARE PROGRAM

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Adult Female Not of Reproductive Potential
 Other: _____ BSA: _____ m² Adult Male Not of Reproductive Potential

Prior Failed Therapies:

Reason for Discontinuation:

Date:

- | | | |
|----------|-------|-------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

If Prior Authorization is Denied: Automatically Draft Appeal for Review Send Formulary Preferred Alternatives

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> AFINITOR®				
<input type="checkbox"/> GLEEVEC®				
<input type="checkbox"/> HYCAMTIN®				
<input type="checkbox"/> SPRYCEL®				
<input type="checkbox"/> TARGRETIN®				
<input type="checkbox"/> TASIGNA®				
<input type="checkbox"/> TEMODAR®				
<input type="checkbox"/> XELODA®				
<input type="checkbox"/> ZOLINZA®				
<input type="checkbox"/> OTHER _____				
Supportive Medications	Dosage & Direction		QTY	Refills
<input type="checkbox"/> Aranesp® <input type="checkbox"/> Granix™ <input type="checkbox"/> Procrit® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Promacta® <input type="checkbox"/> Caphosol® <input type="checkbox"/> Neulasta® <input type="checkbox"/> Sancuso® <input type="checkbox"/> Creon® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Xgeva® <input type="checkbox"/> Emend® <input type="checkbox"/> Nplate® <input type="checkbox"/> Zofran®				

5 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

6 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____
Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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