Oncology

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name:_____ DOB:_____ Gender: ○M ○F

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alt. Phone: _____ Email: _____ Ht: _____ Wt: _____

Care Giver: _____ Allergies: ○ No Known ○ See Attached Charts Other: _____

Please include front and back copies of insurance card

Prescriber Information

Name: _____ NPI: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State:____ Zip:_____ Office Contact: _____

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: _____ **ICD-10:** _____ Other: _____ BSA: _____m^2

○ Adult Female Not of Reproductive Potential ○ Adult Male Not of Reproductive Potential:

Prior Failed Therapies	Reason for Discontinuation	Date

Injection Training: ○ Pharmacist to Provide Training ○ Patient Trained in MD Office ○ Manufacturer Nurse Support

Product Delivery: ○ Patient's Home ○ Physician's Office ○ Pharmacy to Coordinate

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Refills
○ **Afinitor**				
○ **Femara**				
○ **Gleevec**				
○ **Hycamtin**				
○ **Kisqali** ○ **Kisqali Femara Co-Pack**				
○ **Rydapt**				
○ **Sprycel**				
○ **Targretin**				
○ **Tasigna**				
○ **Temodar**				
○ **Xeloda**				
○ **Zolinza**				
○ **Zytiga**				
○ **Other:**				

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: _____ 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.