



FAX REFERRAL TO: 1-888-801-0404
Phone# 888-570-9077

ONCOLOGY ENROLLMENT FORM

Date: _____ • Ship to: Patient Office
 Needs by Date: _____

PATIENT INFORMATION
 (Complete the following *or send patient demographic sheet*)

Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 SS#: _____
 Date of Birth: _____ Sex: M - F

INSURANCE INFORMATION
Primary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)
Secondary Insurance/Prescription Card:
 PLEASE FAX COPY OF INS CARD (front and back if available)

DIAGNOSIS / ICD 10 CODE	SPECIAL INSTRUCTIONS
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	
<input type="checkbox"/> _____	

PRESCRIBER INFORMATION

Prescriber's Name: _____
 DEA #: _____ NPI #: _____
 Group or _____
 Address: _____
 City, State, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____

Other Clinical Information / Comments: _____

Weight: _____ kg or _____ lbs
 Height: _____ inches BSA: _____ m²

Comments / Allergies / Previous therapies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG/DIRECTIONS	QUANTITY	REFIL
<input type="checkbox"/> Afinitor [®]	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg	<input type="checkbox"/> Take one capsule by mouth once a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Xeloda [®]	<input type="checkbox"/> 200mg/m ² in two divided doses: Take _____mg po BID (____ 500mg and ____ 150mg tablets) on days 1-14 of a 21-day cycle <input type="checkbox"/> 250mg/m ² in two divided doses: Take _____mg po BID (____ 500mg and ____ 150mg tablets) on days 1-14 of a 21-day cycle		____ 500mg tabs ____ 150mg tabs	
<input type="checkbox"/> Tassigna [®]	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> ____mg Twice daily on empty stomach <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28 day supply <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Gleevec [®]	<input type="checkbox"/> 100 mg tablet <input type="checkbox"/> 400 mg tablet	<input type="checkbox"/> Take 400mg (one tablet) by mouth once a day <input type="checkbox"/> Take 800mg (two 400mg tablets) by mouth once a day <input type="checkbox"/> Take 600mg (two 100mg tablets and one 400mg tablet) by mouth once a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Tarceva [®]	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg	<input type="checkbox"/> Take 1 tablet once daily on an empty stomach as directed <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Zytiga [®]	<input type="checkbox"/> 250 mg tablets	<input type="checkbox"/> Take 4 tablets (1000mg) once daily on an empty stomach as directed	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Tykerb [®]	<input type="checkbox"/> 250 mg tablets	<input type="checkbox"/> Take 5 tablets once daily one hour before of after a meal for ____ days <input type="checkbox"/> Other: _____	<input type="checkbox"/> ____day supply	
<input type="checkbox"/> Promacta [®]	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg <input type="checkbox"/> 100 mg tablets	<input type="checkbox"/> Take 1 tablet once daily on an empty stomach as directed <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Votrient [®]	<input type="checkbox"/> 200 mg tablets	<input type="checkbox"/> Take 4 tablets (800mg) once daily on an empty stomach as directed <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 day supply	
<input type="checkbox"/> Opdivo [®]	<input type="checkbox"/> 100mg/10ml vial <input type="checkbox"/> 40mg/4ml vial	<input type="checkbox"/> Infuse _____mg over 60 minutes every 2 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Perjeta [®]	<input type="checkbox"/> 420 mg vial	<input type="checkbox"/> 840 mg infused over 60 minutes <input type="checkbox"/> 420 mg infused over 30-60 minutes every 3 weeks	<input type="checkbox"/> 2 vials <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Herceptin [®]	<input type="checkbox"/> 440 mg vial	<input type="checkbox"/> Infuse _____mg every _____week(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Kadcyca [®]	<input type="checkbox"/> 100 mg vial <input type="checkbox"/> 160 mg vial	<input type="checkbox"/> Infuse _____mg (3.6mg/kg) every 3 week(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Faslodex [®]	<input type="checkbox"/> 500 mg kit (2 x 250mg pfs)	<input type="checkbox"/> Inject _____mg on days 1, 15, and 29, then once per month <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 x 500mg kit <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Xgeva [®]	<input type="checkbox"/> 120 mg vial	<input type="checkbox"/> Infuse 120mg every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 Vial <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Neulasta pfs [®]	<input type="checkbox"/> 6 mg pfs	<input type="checkbox"/> Inject 1 syringe every 21 days <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 syringe <input type="checkbox"/> Other: ____	
<input type="checkbox"/> Neupogen pfs [®]	<input type="checkbox"/> 300 mcg <input type="checkbox"/> 480 mcg	<input type="checkbox"/> Inject _____mcg _____	<input type="checkbox"/> ____PFS	
<input type="checkbox"/> Aranesp [®]	<input type="checkbox"/> ____mcg pfs	<input type="checkbox"/> Inject _____mcg _____	<input type="checkbox"/> ____syringes	
<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

I authorize Focus Rx staff or its representatives to act as an agent to initiate and execute any prior authorization on my behalf.

_____ (Date) _____
 Prescriber Signature

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Focus Rx.docx Revised 11/2/15