ONCOLOGY ENROLLMENT FORM

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

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

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: _____m^2

Comments / Allergies / Previous therapies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG/DIRECTIONS	QUANTITY	REFIL
☐ **Afinitor**®	☐ 2.5 mg ☐ 5 mg ☐ 10 mg	☐ Take one capsule by mouth once a day ☐ Other: _____	☐ 4 week supply	
☐ **Xeloda**®	☐ 2000mg/m^2 in two divided doses: Take _____mg po BID (____500mg and ____150mg tablets) on days 1-14 of a 21-day cycle ☐ 2500mg/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	
☐ **Tasigna**®	☐ 150 mg ☐ 200 mg	☐ _____mg Twice daily on empty stomach ☐ Other: _____	☐ 28 day supply ☐ Other: _____	
☐ **Gleevec**®	☐ 100 mg tablet ☐ 400 mg tablet	☐ Take 400mg (one tablet) by mouth once a day ☐ Take 800mg (two 400mg tablets) by mouth once a day ☐ Take 600mg (two 100mg tablets and one 400mg tablet) by mouth once a day ☐ Other: _____	☐ 30 day supply	
☐ **Tarceva**®	☐ 25 mg ☐ 100 mg ☐ 150 mg	☐ Take 1 tablet once daily on an empty stomach as directed ☐ Other _____	☐ 30 day supply	
☐ **Zytiga**®	☐ 250 mg tablets	☐ Take 4 tablets (1000mg) once daily on an empty stomach as directed	☐ 30 day supply	
☐ **Tykerb**®	☐ 250 mg tablets	☐ Take 5 tablets once daily one hour before of after a meal for _____ days ☐ Other _____	☐ ____day supply	
☐ **Promacta**®	☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg ☐ 100 mg tablets	☐ Take 1 tablet once daily on an empty stomach as directed ☐ Other _____	☐ 30 day supply	
☐ **Votrient**®	☐ 200 mg tablets	☐ Take 4 tablets (800mg) once daily on an empty stomach as directed ☐ Other _____	☐ 30 day supply	
☐ **Opdivio**®	☐ 100mg/10ml vial ☐ 40mg/4ml vial	☐ Infuse _____mg over 60 minutes every 2 weeks ☐ Other _____	☐ 28 day supply	
☐ **Perjeta**®	☐ 420 mg vial	☐ 840 mg infused over 60 minutes ☐ 420 mg infused over 30-60 minutes every 3 weeks	☐ 2 vials ☐ Other_____	
☐ **Herceptin**®	☐ 440 mg vial	☐ Infuse _____ mg every _____week(s) ☐ Other: _____	☐ 1 Vial ☐ Other_____	
☐ **Kadcyla**®	☐ 100 mg vial ☐ 160 mg vial	☐ Infuse _____ mg (3.6mg/kg) every 3 week(s) ☐ Other: _____	☐ 1 Vial ☐ Other_____	
☐ **Faslodex**®	☐ 500 mg kit (2 x 250mg pfs)	☐ Inject _____ mg on days 1, 15, and 29, then once per month ☐ Other: _____	☐1 x 500mg kit ☐ Other_____	
☐ **Xgeva**®	☐ 120 mg vial	☐ Infuse 120mg every 4 weeks ☐ Other_____	☐ 1 Vial ☐ Other_____	
☐ **Neulasta pfs** ®	☐ 6 mg pfs	☐ Inject 1 syringe every 21 days ☐ Other_____	☐ 1 syringe ☐ Other_____	
☐ **Neupogen pfs**®	☐ 300 mcg ☐480 mcg	☐ Inject _____ mcg _____	☐ ____PFS	
☐ **Aranesp**®	☐ ____mcg pfs	☐ Inject _____ mcg _____	☐ ____ syringes	
☐ Other_____	☐ Other_____	☐ Other_____		

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

Prescriber Signature (Date)