



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"/> Kadcyła [®]	<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

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