Fax Referral To:
814-283-2211

Phone 855-265-8008

1333 Plank Road, Suite 200, Duncansville, PA 16635

Oncology Enrollment Form

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other**

Date: ______________ **Needs by date** ______________

Is patient new to this therapy? ☐ **YES** ☐ **NO**

Documents necessary for facilitation of referral:

1. **Enrollment form**
2. **Front/Back copies of all insurance/prescription cards**
3. **Copy of most recent labwork and medication profile**

PATIENT INFORMATION

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

Patient Name: ______________
Address: ______________
City, State, Zip: ______________
Home Phone: ______________
Alternate Phone: ______________
SS #: ______________
Date of Birth: ______________ Gender: ______________

PRESCRIBER INFORMATION

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

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10:

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• Date of Diagnosis: ______________

Additional Clinical Information:

Weight: ______________ kg/lbs • Height: ______________ in/cm
Allergies: ______________
Failed Therapies: ______________
Dates of previous therapies: ______________
Reason(s) for discontinuation: ______________
Desired start date of therapy: ______________

Injection Training/Home Health Coordination: Supplies to be sent:

• Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____

• Specialty Pharmacy to coordinate injection training/home health nursing as necessary. ☐ Yes ☐ No

ONCOLYTIC THERAPY	DOSE/DIRECTIONS/ QUANTITY	ADDITIONAL THERAPIES	DOSE/DIRECTIONS/ QUANTITY	SUPPORTIVE MEDICATION	DOSE/DIRECTIONS/ QUANTITY
☐ **Afinitor**					
☐ **Emcyt**					
☐ **Gleevec**					
☐ **Mekinist**		☐ **Aromasin**		☐ **Compazine**	
☐ **Sprycel**		☐ **Dexamethasone**		☐ **Emend Bi-fold**	
☐ **Tafinlar**		☐ **Femara**		☐ **Emend Tri-fold**	
☐ **Targretin**		☐ **Mozobil**		☐ **Kytril**	
☐ **Tasigna**		☐ **Prednisone**		☐ **Neulasta**	
☐ **Temodar**		☐ ______________		☐ **Neupogen**	
☐ **Tykerb**				☐ **Reglan**	
☐ **Xeloda**				☐ ______________	
☐ **Votrient**				☐ ______________	
☐ **Zolinza**					
☐ **Zytiga**					
☐ ______________					

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right

____
Physician Signature (Date)