Oral Oncology Enrollment Form

Date: ______________

Patient Data

Patient Name: ______________________________ Birthdate: ______________
Sex: q Male q Female Height: ______ Weight: _______ lbs kg
SSN #: X X X - X X - ______________________________
Known Allergies: ______________________________
Address: ______________________________
City: ____________________ State: ______________ Zip: ______________
Home Phone: ____________________ Cell Phone: ____________________
Primary Language: ______________________________
Authorized Contact: ______________________________
Contact's Phone: ______________________________

Ins. Data

Primary Insurance: ______________________________
Secondary Insurance: ______________________________
ID: ______________________________ Group#: ____________
ID: ______________________________ Group#: ____________

Clinical Information

To expedite prior authorization, please attach current and past treatment regimen(s)/schedule, last clinical office notes, patient current height and weight, and/or lab values/scans

Diagnosis: ______________________________ **ICD 10 code:** ______________
Secondary Diagnosis: ______________________________ **ICD 10 code:** ______________
Has patient had prior treatment for this diagnosis? ☐ Yes ☐ No **Desired cycle start date:** _______/_______/_______
Date(s) of previous therapy and medication: ______________________________
Reason(s) for discontinuation: ______________________________

Prescription

Medication		Strength/ Directions	Quantity	Refills
☐ Afinitor®	☐ Promacta®			
☐ Akynzeo®	☐ Sprycel®			
☐ Emcyt®	☐ Sylatron®			
☐ Gleevec®	☐ Tafinlar®			
☐ Hycamtin®	☐ Targretin®			
☐ Jadenu®	☐ Tasigna®			
☐ Kasqali®	☐ Temodar®			
☐ Kasqali Femara® Co-Pack	☐ Tykerb®			
☐ Lonsurf®	☐ Xeloda®			
☐ Mekinist™	☐ Votrient®			
☐ Ninlaro®	☐ Zolinza®			
☐ Odomzo®	☐ Zytiga®			

Adjuvant Therapies

Medication		Strength/Directions	Quantity	Refills
☐ Aromasin®	☐ Mozobil			
☐ Dexamethasone	☐ Prednisone			
☐ Femara®				
☐ Other: ______________				

Supportive Medications

Medication		Strength/Directions	Quantity	Refills
☐ Compazine®	☐ Neulasta®			
☐ Emend Bi-fold®	☐ Neupogen®			
☐ Emend Tri-fold®	☐ Reglan®			
☐ Kytril®	☐ Zofran®			
☐ Other: ______________				

Is patient new to this therapy: q YES q NO | **Ship to:** q Patient q Office q Other

Prescriber Data

Prescribers Name: ______________________________
DEA#: ____________________ NPI: ______________
Practice Name: ______________________________
Contact: ______________________________
Address: ______________________________
Phone: ______________________________ Fax: ______________
City: ______________ State: ______________ Zip: ______________
Key Contact#: ______________________________

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 process.

Physician Signature: ______________________________ Date: ______________

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

fax referral to: **844-812-6227** | phone: **855-265-8008** | **www.vsprx.com**