



# Oral Oncology Enrollment Form

Date: \_\_\_\_\_

Patient Data

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs kg  
 SSN #: XXX-XX-\_\_\_\_ 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
<input type="checkbox"/> Afinitor® <input type="checkbox"/> Promacta® <input type="checkbox"/> Akynzeo® <input type="checkbox"/> Sprycel® <input type="checkbox"/> Emcyt® <input type="checkbox"/> Sylatron® <input type="checkbox"/> Gleevec® <input type="checkbox"/> Tafenlar® <input type="checkbox"/> Hycamtin® <input type="checkbox"/> Targretin® <input type="checkbox"/> Jadenu® <input type="checkbox"/> Tassigna® <input type="checkbox"/> Kisqali® <input type="checkbox"/> Temodar® <input type="checkbox"/> Kisqali Femara® Co-Pack <input type="checkbox"/> Tykerb® <input type="checkbox"/> Lonsurf® <input type="checkbox"/> Xeloda® <input type="checkbox"/> Mekinist™ <input type="checkbox"/> Votrient® <input type="checkbox"/> Ninlaro® <input type="checkbox"/> Zolinza® <input type="checkbox"/> Odomzo® <input type="checkbox"/> Zytiga® <input type="checkbox"/> Piqray®			

Adjuvant Therapies

Medication	Strength/Directions	Quantity	Refills
<input type="checkbox"/> Aromasin® <input type="checkbox"/> Mozobil <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Prednisone <input type="checkbox"/> Femara® <input type="checkbox"/> Other: _____			

Supportive Medications

Medication	Strength/Directions	Quantity	Refills
<input type="checkbox"/> Compazine® <input type="checkbox"/> Neulasta® <input type="checkbox"/> Emend Bi-fold® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Emend Tri-fold® <input type="checkbox"/> Reglan® <input type="checkbox"/> Kytril® <input type="checkbox"/> Zofran® <input type="checkbox"/> Other: _____			

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

Prescriber Data

Prescriber 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.

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