



Oral Oncology Enrollment Form

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs kg
 SSN #: XXX-XX-_____
 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"/> Nilandron		
<input type="checkbox"/> Alecensa®	<input type="checkbox"/> Ninlaro®		
<input type="checkbox"/> Aromasin®	<input type="checkbox"/> Odomzo®		
<input type="checkbox"/> Braftovi®	<input type="checkbox"/> Piqray®		
<input type="checkbox"/> Brukinsa™	<input type="checkbox"/> Rydapt®		
<input type="checkbox"/> Casodex	<input type="checkbox"/> Soltamox		
<input type="checkbox"/> Emcyt®	<input type="checkbox"/> Sprycel®		
<input type="checkbox"/> Fareston®	<input type="checkbox"/> Tafinlar®		
<input type="checkbox"/> Farydak®	<input type="checkbox"/> Targretin®		
<input type="checkbox"/> Faslodex®	<input type="checkbox"/> Tasisna®		
<input type="checkbox"/> Gleevec®	<input type="checkbox"/> Temodar®		
<input type="checkbox"/> Hycamtin®	<input type="checkbox"/> Tykerb®		
<input type="checkbox"/> Idhifa®	<input type="checkbox"/> Xeloda®		
<input type="checkbox"/> Inrebic®	<input type="checkbox"/> Xgeva®		
<input type="checkbox"/> Jadenu®	<input type="checkbox"/> Vantas		
<input type="checkbox"/> Kisqali®	<input type="checkbox"/> Votrient®		
<input type="checkbox"/> Kisqali Femara® Co-Pack	<input type="checkbox"/> Yonsa®		
<input type="checkbox"/> Lupron Depot®	<input type="checkbox"/> Zoladex®		
<input type="checkbox"/> Lynparza®	<input type="checkbox"/> Zolinza®		
<input type="checkbox"/> Mekinist™	<input type="checkbox"/> Zykadia®		
<input type="checkbox"/> Mektovi®	<input type="checkbox"/> Zytiga®		

Supportive Therapies

Medication	Strength/Directions	Quantity	Refills
<input type="checkbox"/> Akynzeo®	<input type="checkbox"/> Neulasta®		
<input type="checkbox"/> Compazine®	<input type="checkbox"/> Neupogen®		
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Prednisone		
<input type="checkbox"/> Emend Bi-Fold®	<input type="checkbox"/> Promacta®		
<input type="checkbox"/> Emend Tri-Fold®	<input type="checkbox"/> Reglan®		
<input type="checkbox"/> Exjade®	<input type="checkbox"/> Udenyca®		
<input type="checkbox"/> Femara®	<input type="checkbox"/> Zofran®		
<input type="checkbox"/> Jadenu®	Other: _____		
<input type="checkbox"/> Kytril®			
<input type="checkbox"/> Mozobil			

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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