Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Oncology Enrollment Form

Clear Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821 Single Point of Contact: (724) 515-7053

Start Date:_____ **Ship to:** ☐ Patient ☐ Office _____Other

1. Patient Information

Patient Name: _____ M F DOB: _____ Soc.Sec#_____

Address: _____ Phone #: _____

Caregiver:_____ Allergies: _____ Weight: _____

2. Clinical Information *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

Patient Type *(if applicable)*

- ○ Adult Female NOT of Reproductive Potential
- ○ Adult Female of Reproductive Potential
- ○ Child Female NOT of Reproductive Potential
- ○ Child Female of Reproductive Potential

ICD -10/ Diagnosis Code:_____

BRAF Mutation Present: ☐ V600E ☐ V600K

Prior treatments: _____

Comorbidities: _____

Concomitant Meds: _____

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

Authorization #:_____

Oncolytic Medications			Choice 1:	Choice 2:
☐ Afinitor®	☐ Kisqali®	☐ Tafinlar®	Strength: Sig:	Strength: Sig:
☐ Arimidex®	☐ Kisqali-Femara®	☐ Tamoxifen®		
☐ Emcyt®	☐ Lomustine®	☐ Targretin®		
☐ Empliciti®	☐ Lupron®	☐ Tasigna®		
☐ Etoposide®	☐ Lysodren®	☐ Temodar®	Qty: Refills:	Qty: Refills:
☐ Fareston®	☐ Matulane®	☐ Trelstar®		
☐ Farydak®	☐ Mekinist®	☐ Tykerb®	Choice 3:	Choice 4:
☐ Faslodex®	☐ Ninlaro®	☐ Vantas®		
☐ Femara®	☐ Odomzo®	☐ Votrient®		
☐ Firmagon®	☐ Opdivo®	☐ Xeloda®	Strength: Sig:	Strength: Sig:
☐ Folotyn®	☐ Rydapt®	☐ Yervoy®		
☐ Gleevec®	☐ Soltamox®	☐ Zoladex®		
☐ Hycamtin®	☐ Sprycel®	☐ Zolinza®		
☐ Intron A®	☐ Sylatron®	☐ Zykadia®	Qty: Refills:	Qty: Refills:
☐ Keytruda®	☐ Tabloid®	☐ Zytiga®		

Supportive Medications		Choice 1:	Choice 2:
☐ Aranesp®	☐ Nplate®	Strength: Sig:	Strength: Sig:
☐ Arixtra®	☐ Procrit®		
☐ Emend®	☐ Promacta®		
☐ Exjade®	☐ Sancuso®		
☐ Granix®	☐ Sandostatin®		
☐ Jadenu®	☐ Sandostatin LAR®		
☐ Lovenox®	☐ Zarxio®		
☐ Neulasta®	☐ Zofran®	Qty: Refills:	Qty: Refills:
☐ Neupogen®	☐ _____		

Please fax list of patient's other medications & choose packaging: ○ AccuPAC® ○ Bottles

☐ **Check Here** to receive more information about our custom compliance packaging *AccuPAC®*

4. Prescriber Information

Preferred Method of Contact: ○ phone ○ fax ○ email

Prescriber (print) : _____ Office Contact:_____

Contact email:_____ Phone:_____ Fax:_____

Office Address: _____ NPI:_____

Prescriber Signature:_____ Date:_____ DEA: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.