



# Oncology Enrollment 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) ICD -10/ Diagnosis Code: \_\_\_\_\_

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

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:
<input type="checkbox"/> Afinitor®	<input type="checkbox"/> Kisqali®	<input type="checkbox"/> Tafenlar®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/> Arimidex®	<input type="checkbox"/> Kisqali-Femara®	<input type="checkbox"/> Tamoxifen®		
<input type="checkbox"/> Emcyt®	<input type="checkbox"/> Lomustine®	<input type="checkbox"/> Targretin®	Qty: Refills:	Qty: Refills:
<input type="checkbox"/> Empliciti®	<input type="checkbox"/> Lupron®	<input type="checkbox"/> Tassigna®		
<input type="checkbox"/> Etoposide®	<input type="checkbox"/> Lysodren®	<input type="checkbox"/> Temodar®	Choice 3:	Choice 4:
<input type="checkbox"/> Fareston®	<input type="checkbox"/> Matulane®	<input type="checkbox"/> Trelstar®		
<input type="checkbox"/> Farydak®	<input type="checkbox"/> Mekinist®	<input type="checkbox"/> Tykerb®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/> Faslodex®	<input type="checkbox"/> Ninlaro®	<input type="checkbox"/> Vantas®		
<input type="checkbox"/> Femara®	<input type="checkbox"/> Odomzo®	<input type="checkbox"/> Votrient®	Qty: Refills:	Qty: Refills:
<input type="checkbox"/> Firmagon®	<input type="checkbox"/> Opdivo®	<input type="checkbox"/> Xeloda®		
<input type="checkbox"/> Folutyn®	<input type="checkbox"/> Rydapt®	<input type="checkbox"/> Xgeva®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/> Gleevec®	<input type="checkbox"/> Soltamox®	<input type="checkbox"/> Yervoy®		
<input type="checkbox"/> Hycamtin®	<input type="checkbox"/> Sprycel®	<input type="checkbox"/> Zoladex®	Qty: Refills:	Qty: Refills:
<input type="checkbox"/> Intron A®	<input type="checkbox"/> Sylatron®	<input type="checkbox"/> Zolinza®		
<input type="checkbox"/> Keytruda®	<input type="checkbox"/> Tabloid®	<input type="checkbox"/> Zykadia®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Zytiga®		

Supportive Medications		Choice 1:	Choice 2:
<input type="checkbox"/> Aranesp®	<input type="checkbox"/> Nplate®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/> Arixtra®	<input type="checkbox"/> Procrit®		
<input type="checkbox"/> Emend®	<input type="checkbox"/> Promacta®	Qty: Refills:	Qty: Refills:
<input type="checkbox"/> Exjade®	<input type="checkbox"/> Sancuso®		
<input type="checkbox"/> Granix®	<input type="checkbox"/> Sandostatin®	Strength: Sig:	Strength: Sig:
<input type="checkbox"/> Jadenu®	<input type="checkbox"/> Sandostatin LAR®		
<input type="checkbox"/> Lovenox®	<input type="checkbox"/> Zarxio®	Qty: Refills:	Qty: Refills:
<input type="checkbox"/> Neulasta®	<input type="checkbox"/> Zofran®		
<input type="checkbox"/> Neupogen®	<input type="checkbox"/>	Strength: Sig:	Strength: Sig:

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.**