Oral Oncology Enrollment Form (A-O)

PRx

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

ONC-AORX-20-01

CLINICAL CONSIDERATIONS

☐ ICD10: _____

Diagnosis: _____

Mutation(s): _____

Past Medical History:

History of therapies tried/failed and reason for discontinuation (please include dates):

Immunization History
☐ Influenza
Date: ____ /____ / ____

Patient Type:
☐Adult Female – Reproductive Potential ☐Adult Female – NOT of Reproductive Potential ☐Adult Male
☐Female Child – Reproductive Potential ☐Female Child – NOT of Reproductive Potential ☐Male Child

℞

Medication	Directions	Quantity	Refills
☐ **Afinitor®** (everolimus)	☐ Take 10 mg by mouth once daily with a full glass of water ☐ Take_____ mg by mouth once daily with a full glass of water	☐ 28 x 10 mg tablets ☐ _____	
☐ **Casodex®** (bicalutamide)	☐ Take 50 mg by mouth once daily	☐ 30 x 50 mg tablets	
☐ **Farydak®** (panobinostat)	☐ Take 20 mg by mouth once daily on days 1, 3, 5, 8, 10, and 12 of a 21-day cycle ☐ Other:_____	☐ 6 x 20 mg capsules ☐ _____	
☐ **Dexamethasone**	☐ Take 20 mg by mouth once daily with food on days 1, 2, 4, 5, 8, 9, 11, and 12 of a 21-day cycle	☐ 40 x 4 mg tablets ☐ _____	
☐ **Gleevec®** (imatinib)	☐ Take 400 mg by mouth once daily with a meal and a full glass of water ☐ Take 600 mg by mouth once daily with a meal and a full glass of water ☐ Take 400 mg by mouth two times a day with a meal and a full glass of water ☐ Take _____mg (340 mg/m^2/day x ____ m^2) by mouth once daily with a meal and a full glass of water ☐ Other:_____	☐ 30 x 400 mg tablets ☐ 30 x 400 mg tablets plus 60 x 100 mg tablets ☐ 60 x 400 mg tablets ☐ _____	
☐ **Hycamtin®** (topotecan)	☐ Take _____ mg (2.3 mg/m^2/day x _____ m^2) by mouth once daily on days 1-5 of a 21-day cycle ☐ Other:_____	☐ _____ x 1 mg capsules plus _____x 0.25 mg capsules ☐ _____	
☐ **Hydrea®** (hydroxyurea)	☐ Take ____ mg (40 mg/kg/day x ____ kg) by mouth once daily ☐ Take 1,000 mg by mouth every 12 hours for 11 doses per cycle ☐ Other:_____	☐ ____ x 500 mg capsules	
☐ **IDHIFA®** (enasidenib)	☐ Take 100 mg by mouth once daily ☐ Other:_____	☐ 30 x 100 mg tablets ☐ _____	
☐ **Inrebic®** (fedratinib)	☐ Take 400 mg by mouth once daily with or without food ☐ Other:_____	☐ 120 x 100 mg capsules ☐ _____	
☐ **Mekinist®** (trametinib)	☐ Take 2 mg by mouth once daily on an empty stomach ☐ Other:_____	☐ 30 x 2 mg tablets ☐ _____ x 0.5 mg tablets	
☐ **Nilandron®** (nilutamide)	☐ **Initial:** Take 300 mg by mouth once daily for 30 days, then maintenance dose ☐ **Maintenance:** Take 150 mg by mouth once daily	☐ 30 x 150 mg tablets	
☐ **Odomzo®** (sonidegib)	☐ Take 200 mg by mouth once daily on an empty stomach	☐ 30 x 200 mg capsules	

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____