Oral Oncology Enrollment Form (P-T)

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 #: _____

ONCPTRX-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
☐ **Rydapt®** (midostaurin)	☐ Take 50 mg by mouth twice daily with food on days 8-21 of each cycle ☐ Take 100 mg by mouth twice daily with food ☐ Other:_____	☐ 56 x 25 mg capsules ☐ 224 x 25 mg capsules ☐ _____	
☐ **Sprycel®** (dasatinib)	☐ Take 100 mg by mouth once daily ☐ Take 140 mg by mouth once daily ☐ Other:_____	☐ 30 x 100 mg tablets ☐ 30 x 140 mg tablets ☐ _____ (available in 20 mg, 50 mg, 70 mg, 80 mg, 100 mg, and 140 mg tablets)	
☐ **Tafinlar®** (dabrafenib)	☐ Take 150 mg by mouth twice daily (every 12 hours) on an empty stomach ☐ Other:_____	☐ 120 x 75 mg capsules ☐ _____ x 50 mg capsules ☐ _____	
☐ **Tarceva®** (erlotinib)	☐ Take 100 mg by mouth once daily on an empty stomach ☐ Take 150 mg by mouth once daily on an empty stomach ☐ Other:_____	☐ 30 x 100 mg tablets ☐ 30 x 150 mg tablets ☐ _____	
☐ **Targretin®** (bexarotene)	☐ Take _____mg (300 mg/m^2/day x _____ m^2) by mouth once daily with a meal	☐ _____ x 75 mg capsules	
☐ **Tasigna®** (nilotinib)	☐ Take 300 mg by mouth twice daily (every 12 hours) on an empty stomach ☐ Take 400 mg by mouth twice daily (every 12 hours) on an empty stomach ☐ Other_____	☐ 112 x 150 mg capsules ☐ 112 x 200 mg capsules ☐ _____	
☐ **Temodar®** (temozolomide)	☐ Take _____mg (75 mg/m^2/day x _____ m^2) by mouth once daily on an empty stomach with a full glass of water on days _____ of a _____ - day cycle ☐ Take _____mg (150/mg m^2/day x _____ m^2) by mouth once daily on an empty stomach with a full glass of water on days 1-5 of a 28-day cycle ☐ Other_____	☐ _____ (available in 5 mg, 20 mg, 100 mg, 140 mg, 180 mg, and 250 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." on the prescription.

SHIPPING INFORMATION

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