Oral Oncology Enrollment Form (V-Z)

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 #: _____

ONCVZRX-20-0

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
☐ **Votrient®** (pazopanib)	☐ Take 800 mg by mouth once daily on an empty stomach ☐ Other:_____	☐ 120 x 200 mg tablets ☐ _____	
☐ **Xeloda®** (capecitabine)	☐ Take _____ mg (1250 mg/m^2/dose x _____ m^2) by mouth twice daily (every 12 hours) within 30 minutes after a meal on days 1-14 of a 21-day cycle ☐ Other:_____	☐ _____ x 150 mg tablets ☐ _____ x 500 mg tablets ☐ _____	
☐ **Yonsa®** (abiraterone)	☐ Take 500 mg (four 125 mg tablets) by mouth once daily	☐ 120 x 125 mg tablets	
Patient will be obtaining methylprednisolone at: ☐ PANTHERx (fill prescription below) ☐ Other Pharmacy ☐ Not receiving (Reason:_____)			
☐ **Methylprednisolone**	☐ Take 4 mg by mouth twice daily with food	☐ 60 x 4 mg tablets	
☐ **Zolinza®** (vorinostat)	☐ Take 400 mg by mouth once daily with food ☐ Other_____	☐ 120 x 100 mg capsules ☐ _____	
☐ **Zykadia®** (ceritinib)	☐ Take 450 mg (three 150 mg tablets) by mouth once daily with food ☐ Other:_____	☐ 84 x 150 mg tablets ☐ _____	
☐ **Zytiga®** (abiraterone)	☐ Take 1,000 mg by mouth once daily on an empty stomach ☐ Other_____	☐ 120 x 250 mg tablets ☐ 60 x 500 mg tablets	
Patient will be obtaining prednisone at: ☐ PANTHERx (fill prescription below) ☐ Other Pharmacy ☐ Not receiving (Reason:_____)			
☐ **Prednisone**	☐ Take 5 mg by mouth twice daily with food	☐ 60 x 5 mg tablets	

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: ____ /____ / ____