



# Oncology – Revlimid, Pomalyst, Thalomid Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

## PATIENT INFORMATION *Please complete the following or send patient demographic sheet*

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
 Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name _____ NPI _____ DEA _____ Group/Hospital _____ Address _____ City, State, ZIP _____ Phone _____ Fax _____ Contact Person _____ Phone _____	Prescriber's Name _____ NPI _____ Office Contact _____ Prescriber's Name _____ NPI _____ Office Contact _____ Prescriber's Name _____ NPI _____ Office Contact _____
--	---

## INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION *(Section must be completed to process prescription) (Attach separate sheet if needed)*

<b>Diagnosis</b> — Please include diagnosis name with ICD-10 code <input type="checkbox"/> ICD-10 _____ Description _____ <b>Test Results:</b> <input type="checkbox"/> SCr/CrCl _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> LFTs _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Hgb/Hct _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> WBC _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Electrolytes _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CT/MRI/Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Additional Information</b> Therapy: <input type="checkbox"/> New <input type="checkbox"/> Reauthorization <input type="checkbox"/> Restart Weight _____ kg/lbs Height _____ cm/in BSA _____ m <sup>2</sup> Allergies _____ Prior Therapies _____ Concomitant Medications _____ Additional Comments _____ Current Cycle # _____ Total # of Cycles _____
--	--

Pomalyst® Physician Authorization # \_\_\_\_\_ Diagnosis:  MMC90.00  Date \_\_\_\_\_  
 Revlimid® Physician Authorization # \_\_\_\_\_ Diagnosis:  MDS D45.9  MMC90.00  Date \_\_\_\_\_  
 Thalomid® Physician Authorization # \_\_\_\_\_ Diagnosis:  MMC90.00  Date \_\_\_\_\_

**Pregnancy Category:**  Adult Female – NOT of Reproductive Potential  Adult Female – Reproductive Potential  Adult Male  
 Female Child – NOT of Reproductive Potential  Female Child – Reproductive Potential  Male Child

## PRESCRIPTION INFORMATION

### Medication

	Dose / Strength	Directions	Therapy Cycle	Quantity
<input type="checkbox"/> Revlimid				
<input type="checkbox"/> Pomalyst				
<input type="checkbox"/> Thalomid				

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date: \_\_\_\_\_ Supervising Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.