

Specialty Pharmacy Enrollment Form**This form is not a valid prescription in Arizona**

Please detach before submitting to a pharmacy - tear here

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____

Address _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: English Spanish Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA/NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

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

Prior Authorization Reference number _____ PA approved until (if known): _____

MEDICAL INFORMATION (Section must be completed to process prescription)

Diagnosis ICD10 _____

Description _____

Description/Stage _____

Test Results: **Included:**

Please fax the following documentation:

BMP or CMP _____ Yes No

CBC or CBC w/ differential _____ Yes No

CT/MRI/Other imaging studies _____ Yes No

Chart/Surgical Notes _____ Yes No

Genetic/diagnostic testing results _____ Yes No

Other relevant results _____ Yes No

Additional Information Therapy: New Reauthorization Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m²

Allergies _____

Prior Failed Therapies _____

History of drug resistance due to neutralizing immune antibody formations _____

Concomitant Medications _____

Additional Comments _____

Cumulative dose (applicable to anthracyclines) _____

Current Cycle # _____ Total # of Cycles _____

PRESCRIPTION INFORMATION**Medication**

- | | | | | | | | | |
|---------------------------------------|---|-------------------------------------|--|-------------------------------------|-------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> Abiraterone | <input type="checkbox"/> Copiktra | <input type="checkbox"/> Everolimus | <input type="checkbox"/> Iressa | <input type="checkbox"/> Mekinist* | <input type="checkbox"/> Perjeta* | <input type="checkbox"/> Stivarga* | <input type="checkbox"/> Toremifene | <input type="checkbox"/> Zelboraf* |
| <input type="checkbox"/> Afinitor | <input type="checkbox"/> Cotellic™ | <input type="checkbox"/> Farydak* | <input type="checkbox"/> Jakafi* | <input type="checkbox"/> Mektovi | <input type="checkbox"/> Piqray | <input type="checkbox"/> Sutent* | <input type="checkbox"/> Tretinoin | <input type="checkbox"/> Zolanza* |
| <input type="checkbox"/> Alecensa* | <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> Gleevec | <input type="checkbox"/> Keytruda* | <input type="checkbox"/> Melphalan | <input type="checkbox"/> Promacta | <input type="checkbox"/> Tabloid* | <input type="checkbox"/> Tykerb* | <input type="checkbox"/> Zydrelig |
| <input type="checkbox"/> Alunbrig™ | <input type="checkbox"/> Daurismo | <input type="checkbox"/> Gleostine* | <input type="checkbox"/> Kisqali* | <input type="checkbox"/> Mesnex | <input type="checkbox"/> Purixan* | <input type="checkbox"/> Tabrecta™ | <input type="checkbox"/> Venclexta | <input type="checkbox"/> Zykadia™ |
| <input type="checkbox"/> Bexarotene | <input type="checkbox"/> Deferasirox tablet | <input type="checkbox"/> Hycamtin* | <input type="checkbox"/> Kisqali* & Femara | <input type="checkbox"/> Nerlynx | <input type="checkbox"/> Retevmo™ | <input type="checkbox"/> Tagrisso | <input type="checkbox"/> Verzenio* | <input type="checkbox"/> Zytiga |
| <input type="checkbox"/> capsules | <input type="checkbox"/> for suspension | <input type="checkbox"/> Ibrance* | <input type="checkbox"/> Nexavar* | <input type="checkbox"/> Nexavar* | <input type="checkbox"/> Retevmo™ | <input type="checkbox"/> Tagrisso | <input type="checkbox"/> Vizimpro* | <input type="checkbox"/> |
| <input type="checkbox"/> Bosulif* | <input type="checkbox"/> Deferasirox | <input type="checkbox"/> Idhifa | <input type="checkbox"/> Lenvima | <input type="checkbox"/> Nilandron* | <input type="checkbox"/> Rozlytrek* | <input type="checkbox"/> Talzena* | <input type="checkbox"/> Votrient* | <input type="checkbox"/> Please see |
| <input type="checkbox"/> Bratovi | <input type="checkbox"/> film coated tablet | <input type="checkbox"/> Imatinib | <input type="checkbox"/> Leukeran* | <input type="checkbox"/> Ninlaro* | <input type="checkbox"/> Rubraca | <input type="checkbox"/> Tarceva | <input type="checkbox"/> Xalkori* | <input type="checkbox"/> attached orders |
| <input type="checkbox"/> Cabometyx* | <input type="checkbox"/> Erivedge* | <input type="checkbox"/> Imbruvica | <input type="checkbox"/> Lonsurf | <input type="checkbox"/> Nubeqa™ | <input type="checkbox"/> Rydapt* | <input type="checkbox"/> Targretin* | <input type="checkbox"/> Xeloda | |
| <input type="checkbox"/> Calquence | <input type="checkbox"/> Erleada™ | <input type="checkbox"/> Inlyta* | <input type="checkbox"/> Lorbreina | <input type="checkbox"/> Odomez* | <input type="checkbox"/> Scemblix | <input type="checkbox"/> Targretin* gel | <input type="checkbox"/> Xtandi* | |
| <input type="checkbox"/> Capecitabine | <input type="checkbox"/> Erlotinib | <input type="checkbox"/> Inqovi | <input type="checkbox"/> Lumakras | <input type="checkbox"/> Onureg | <input type="checkbox"/> Sorafenib | <input type="checkbox"/> Onureg | <input type="checkbox"/> Yonsa* | |
| <input type="checkbox"/> Cometriq | <input type="checkbox"/> Etoposide | <input type="checkbox"/> Inrebic* | <input type="checkbox"/> Lynparza | <input type="checkbox"/> Opdivo* | <input type="checkbox"/> Sprycel* | <input type="checkbox"/> Temozolomide | <input type="checkbox"/> Zejula | |

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

 Infusable _____

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

Ship to: Patient Office Other _____ Date _____ Needs by Date _____

*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.

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.