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ONCOLOGY ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:______________________ Caregiver: ______________________

DOB:________ ☐ Male ☐ Female Weight:______ ☐ kgs or ☐ lbs (check one) Height______ ☐ in or ☐ cm (check one) Recorded Date: ____________

Address:______________________ City: ______________________ State: _______ Zip: ____________

Best Phone #:______________________ ☐ Cell Alternate Phone #:______________________ ☐ Cell Email:______________________

Allergies:______________________ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: ______________________ ICD-10 Code(s) for other medical conditions: ______________________

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Renal Dysfunction ☐ Yes ☐ No

Current SCR ______________________ or current GFR______________________ mt/min

Liver Dysfunction ☐ Yes ☐ No

Abnormal Lab Value(s) ______________________

H/H (Hemoglobin/Hematocrit) ______________________

Confirmed Mutations: ☐ EGDR ☐ ALK ☐ BRAF V600E ☐ BRAF V600K

☐ CLL with 17p deletion ☐ Other______________________

COMPLETE THIS SECTION ONLY IF YOU WOULD LIKE USSC TO INITIATE A PRIOR AUTHORIZATION OR APPEAL ON YOUR BEHALF:

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
______________________	☐ Disease Progression	______________________
______________________	☐ Finished Therapy	______________________
______________________	☐ Toxicity: ______________________	______________________

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION

ORAL ONCOLYTICS

☐ Afinitor ___ mg ☐ Afinitor Disperz____mg ☐ Bosulif ____mg ☐ Gleevec____ mg

☐ Sprycel____mg ☐ Targretin____mg ☐ Tasigna____mg ☐ Temodar____mg

☐ Xeloda____mg ☐ Zolinza____mg ☐ ______________________ mg

☐ Other______________________

QTY: ______________________

DOSING & SIG: ______________________

Refill #: ______________________

**Authorization #: ______________________

SUPPORT DRUGS

☐ Aranesp: ○ Vials ○ Prefilled Syringes ☐ Arixtra ___mg/___ml ☐ Caphosol ___ml

☐ Emend ___mg ☐ Lovenox ___mg/___ml ☐ Neulasta___mg/___ml

☐ Neupogen: ○ Vials ○ Prefilled Syringes ☐ Procrit____units ☐ Sancuso___mg/24hr

☐ Zofran ___mg ☐ Zofran ODT ___mg

☐ Other______________________

QTY: ______________________

DOSING & SIG: ______________________

Refill #: ______________________

INJECTION TRAINING: ☐ **OFFICE TO COORDINATE** ☐ **USSC TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: ______________________________ Prescriber Specialty: ____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:____

Fax #: _________________________________Contact Name: ____

Office Address: ____ City: ______________________________ State:_____ Zip:________

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☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: ____Prescriber's Signature: _____________________________________Date: ___________

☐ Use substitution ☐ Dispense as Written

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