ONCOLOGY SPECIALTY CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**

1 PATIENT INFORMATION:

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Alt. Phone: ____________

Email: ______________________________

DOB: ________ Gender: ❍ M ❍ F Caregiver: ________

Height: ______ Weight: ______ Allergies: ________

2 PRESCRIBER INFORMATION:

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Phone: ____________ Fax: ____________

NPI: ____________ DEA: ____________

Tax I.D.: ______________________________

Office Contact: ____________ Phone: ____________

v9.6_041918

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: __________ ICD-10: ______________________

Other: ______________ BSA: ________ m²

❑ Adult Female Not of Reproductive Potential

❑ Adult Male Not of Reproductive Potential

	Prior Failed Therapies:	Reason for Discontinuation:	Date:
1.			
2.			
3.			
4.			

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: ______________________________ Patient's Date of Birth: ____________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ AFINITOR®				
❑ FEMARA®				
❑ GLEEVEC®				
❑ HYCAMTIN®				
❑ KISQALI® ❑ KISQALI® FEMARA® Co-Pack				
❑ RYDAPT®				
❑ SPRYCEL®				
❑ TARGRETIN®				
❑ TASIGNA®				
❑ TEMODAR®				
❑ XELODA®				
❑ ZOLINZA®				
❑ ZYTIGA®				
❑ OTHER ____________				

Supportive Medications				Dosage & Direction	QTY	Refills
❑ Aranesp® ❑ Arixtra® ❑ Caphosol® ❑ Creon®	❑ Emend® ❑ Granix® ❑ Lovenox® ❑ Neulasta®	❑ Neupogen® ❑ Nplate® ❑ Procrit® ❑ Promacta®	❑ Sancuso® ❑ Xgeva® ❑ Zofran®			

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ______________________ Date: ________ Signature: ______________________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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