Oncology General Enrollment Form

Fax Referral To: 1-718-261-6689
Email Referral To: info@healthycornerpharmacy.com
Phone: 1-855-261-6699

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

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

Diagnosis (ICD-10):

☐ Code: _____ Description: _____ ☐ Code: _____ Description: _____

For additional ICD-10 information, please visit www.icd10-data.com

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg
Concomitant Medications: _____
Additional Comments: _____

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Site of Care: ☐ MD office ☐ Infusion Clinic ☐ Outpatient Health ☐ Home Health
Injection training not necessary. Date training occurred: _____
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD to alternate trainer

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

Administration Supplies:

Quantity	Description	QUANTITY/REFILLS
☐ Other: _____	☐ Other: _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)
X_____

DISPENSE AS WRITTEN (Date)
X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize Healthy Corner Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.