Oncology Oral Medications Enrollment Form

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

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: _____ Weight: _____lb/kg Height: _____in/cm BSA: _____ m^2

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.

Medications A-Z
Oncology Oral Medications Enrollment Form

Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

Medications:

- ☐ Revlimid REMS™ Program Physician Auth #: _____ Date: _____
- ☐ Pomalyst REMS™ Program Physician Auth #: _____ Date: _____
- ☐ Thalomid REMS™ Program Physician Auth #: _____ Date: _____

Diagnosis:

- ☐ MDS D46.9
- ☐ MM C90.00
- ☐ MCL C83.10

Pregnancy Category:

- ☐ Adult Female – Reproductive Potential
- ☐ Female Child – Reproductive Potential
- ☐ Adult Female – NOT of Reproductive Potential
- ☐ Female Child – NOT of Reproductive Potential
- ☐ Adult Male
- ☐ Male Child

Medications:

- ☐ Afinitor® (everolimus)
- ☐ Afinitor® Disperz (everolimus)
- ☐ Alecensa® (alectinib)
- ☐ Alunbrig™ (brigatinib)
- ☐ Bosulif® (bosutinib)
- ☐ Cabometyx™ (cabozantinib)
- ☐ Cotellic™ (cobimetinib)
- ☐ Erivedge® (vismodegib)
- ☐ Erleada™ (apalutamide)
- ☐ Farydak® (panobinostat)
- ☐ Gleevec® (imatinib mesylate)
- ☐ Hycamtin® Capsules (topotecan)
- ☐ Ibrance® (palbociclib)
- ☐ Idhifa® (enasidenib)
- ☐ Inlyta® (axitinib)
- ☐ Iressa® (gefitinib)
- ☐ Jakafi® (ruxolitinib)
- ☐ Kisqali® (ribociclib)
- ☐ Lenvima® (lenvatinib)
- ☐ Lonsurf® (trifluridine & tipiracil)
- ☐ Lorbrena® (lorlatinib)
- ☐ Lynparza® (olaparib)
- ☐ Mekinist® (trametinib)
- ☐ Nerlynx™ (neratinib)
- ☐ Nexavar® (sorafenib)
- ☐ Ninlaro® (ixazomib)
- ☐ Odomzo® (sonidegib)
- ☐ Pomalyst® (pomalidomide)
- ☐ Purixan® (mercaptopurine)
- ☐ Revlimid® (lenalidomide)
- ☐ Rubraca™ (rucaparib)
- ☐ Rydapt® (midostaurin)
- ☐ Sprycel® (dasatinib)
- ☐ Stivarga® (regorafenib)
- ☐ Sutent® (sunitinib malate)
- ☐ Tafinlar® (dabrafinib)
- ☐ Tagrisso™ (osimertinib)
- ☐ Talzenna® (talazoparib)
- ☐ Tarceva® (erlotinib HCl)
- ☐ Targretin® Capsules (bexarotene)
- ☐ Tasigna® (nilotinib)
- ☐ Temodar® Capsules (temozolomide)
- ☐ Thalomid® (thalidomide)
- ☐ Tykerb® (lapatinib)
- ☐ Verzenio™ (abemaciclib)
- ☐ Vitrakvi® (larotrectinib)
- ☐ Vizimpro® (dacomitinib)
- ☐ Votrient® (pazopanib)
- ☐ Xalkori® (crizotinib)
- ☐ Xeloda® (capecitabine)
- ☐ Xtandi® (enzalutamide)
- ☐ Zelboraf® (vemurafenib)
- ☐ Zolinza® (vorinostat)
- ☐ Zydelig® (idelalisib)
- ☐ Zykadia™ (ceritinib)
- ☐ Zytiga® (abiraterone)
- ☐ Other: _____

PRESCRIPTIONS	DRUG NAME/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 2	☐ Other: _____	☐ Other: _____	Quantity:_____ Refills:_____
RX 3	☐ Dexamethasone ☐ Exemastane ☐ Letrozole ☐ Prednisone	☐ 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_____

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