

ONCOLOGY ENROLLMENT FORM



**QUALITY SPECIALTY
PHARMACY**

2233 Lomita Blvd, Lomita, CA 90717
SERVICING ALL YOUR PHARMACY NEEDS

Prescriber Name: _____
 Group or Institution: _____
 DEA#: _____ NPI: _____
 Address: _____
 City, /State, Zip: _____
 Phone: _____ Fax: _____
 Office Contact: _____
 Office Email: _____

FAX PRESCRIPTION TO: _____
REP Contact: _____

Needs by Date: _____ SHIP TO: Patient MD Office
 Injection Training / Home Health Nursing Instruction Required

1 PATIENT INFORMATION:

Patient Name: _____ Gender: M F
 Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip: _____ Primary Language: _____
 Home Phone: _____ Cell: _____ Email: _____

2 INSURANCE INFORMATION - PLEASE FAX COPY OF FRONT & BACK OF PRIMARY/SECONDARY PRESCRIPTION INSURANCE CARDS

3 DIAGNOSIS AND CLINICAL INFORMATION - PRESCRIBER MUST PROVIDE IN ORDER TO EXPEDITE THE PRIOR AUTHORIZATION

Diagnosis Description: _____ ICD-10: _____
 Diagnosis Description: _____ ICD-10: _____

TREATMENT CYCLE: _____ **REST PERIOD:** _____

Height: _____ inch/ft Weight: _____ lb/kg BSA: _____ m²
 Allergies: _____ NKDA

Prior Tried & Failed Medications - information must be provided to avoid prior auth denials:

Medication/Strength:	Duration:	Reason for Discontinuation:
_____	_____	_____
_____	_____	_____
_____	_____	_____

4 PRESCRIPTION INFORMATION - please include TREATMENT CYCLE and REST PERIOD - mandatory for prior auth & billing

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Xeloda	<input type="checkbox"/> 150 mg tab			
<input type="checkbox"/> capecitabine	<input type="checkbox"/> 500 mg tab			
<input type="checkbox"/> Temodar	<input type="checkbox"/> 5 mg <input type="checkbox"/> 20 mg cap <input type="checkbox"/> 100 mg <input type="checkbox"/> 140 mg cap			
<input type="checkbox"/> temozolomide	<input type="checkbox"/> 250 mg cap <input type="checkbox"/> 100 mg/vial			
<input type="checkbox"/> Zytiga	<input type="checkbox"/> 250 mg tab	1000 mg po QD; use with prednisone		
<input type="checkbox"/> Gleevec	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg tab			
<input type="checkbox"/> Sprycel	<input type="checkbox"/> 20 mg <input type="checkbox"/> 50 mg tab <input type="checkbox"/> 70 mg <input type="checkbox"/> 80 mg tab <input type="checkbox"/> 100 mg <input type="checkbox"/> 140 mg tab			
<input type="checkbox"/> Afinitor	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg tab <input type="checkbox"/> 7.5 mg <input type="checkbox"/> 10 mg tab			
<input type="checkbox"/> Tasigna	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg cap			
<input type="checkbox"/> Mitomycin IV Vials	<input type="checkbox"/> 5mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg			
<input type="checkbox"/> Other:				

Quality Specialty Pharmacy Can Assist with Benefit Verification & Patient Support for the following Limited Distribution Products:

- Ibrance Inlyta Jakafi Nexavar Stivarga Sutent Tarceva Tykerb
 Revlimid Pomalyst Thalomid Xtandi

* Please use "other" section above to write prescription

5 PRESCRIBER SIGNATURE REQUIRED

Dispense as written Initial _____

Prescriber Signature: _____ Date: _____

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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