ONCOLOGY ENROLLMENT FORM

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

FAX PRESCRIPTION TO: 1-800-516-4645
REP Contact: Michelle Moeller TEL: 888-631-6982

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

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

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:** _____ m^2

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
☐ **Xeloda** ☐ **capecitabine**	☐ 150 mg tab ☐ 500 mg tab			
☐ **Temodar** ☐ **temozolomide**	☐ 5 mg ☐ 20 mg cap ☐ 100 mg ☐ 140 mg cap ☐ 250 mg cap ☐ 100 mg/vial			
☐ **Zytiga**	☐ 250 mg tab	1000 mg po QD; use with prednisone		
☐ **Gleevec**	☐ 100 mg ☐ 400 mg tab			
☐ **Sprycel**	☐ 20 mg ☐ 50 mg tab ☐ 70 mg ☐ 80 mg tab ☐ 100 mg ☐ 140 mg tab			
☐ **Afinitor**	☐ 2.5 mg ☐ 5 mg tab ☐ 7.5 mg ☐ 10 mg tab			
☐ **Tasigna**	☐ 150 mg ☐ 200 mg cap			
☐ **Mitomycin** IV Vials	☐ 5mg ☐ 20 mg ☐ 40 mg			
☐ **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:** _____