Gigi Specialty Pharmacy

Oncology Enrollment Form
Patient Information

A Dose Of Kindness With Every Perscription.

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed:_____ **Rx:** ☐ New ☐ Refill _____

Patient Information

Date:_____ Patient SS#:_____ **DIAGNOSIS DESCRIPTION:**_____ **ICD9 CODE:**_____

☐ Adult Male ☐ Child Male ☐ Adult Female Not of Reproductive Potential ☐ Adult Female of Reproductive Potential
☐ Female Child Not of Reproductive Potential ☐ Female Child of Reproductive Potential

Patient's First Name: _____ Patient's Last Name:_____

Address:_____ City/County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____

Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY:_____

Prescription

ORAL ONCOLYTICS

☐ Afinitor	☐ Gleevec	☐ Pomalyst**	☐ Tamoxifen	☐ Xeloda
☐ Arimidex	☐ Hycamtin	☐ Revlimid**	☐ Tarceva	☐ Xtandi
☐ Bosulif	☐ Imbruvica	☐ Sprycel	☐ Tasigna	☐ Zolinza
☐ Cometriq	☐ Inlyta	☐ Sutent	☐ Temodar	☐ _____
☐ Erivedge	☐ Jakafi	☐ Stivarga	☐ Thalomid**	
* Exjade	☐ Mekinist	☐ Sylatron	☐ Tykerb	
☐ Femara	☐ Nexavar	☐ Tafinlar	☐ Votrient	

QTY:
DOSING & SIG:

Refill #:_____

****Authorization #:** _____

☐ Zelboraf ☐ Tafinlar BRAF V600E mutation positive melanoma as detected by an FDA-approved test? ☐ Yes ☐ No

☐ Mekinist BRAF V600E or V600K mutation positive melanoma as detected by an FDA-approved test? ☐ Yes ☐ No

☐ Zytiga Qty:_____ 250mg 4 QD w/o food ☐ Zytiga Refill #:_____

☐ WITH Prednisone Qty:_____ 5mg BID w/ food Prednisone Refill #:_____

SUPPORT DRUGS

☐ Aranesp	☐ Arixtra	☐ Caphosol	☐ Emend	☐ Lovenox	☐ Neulasta
☐ Neupogen	☐ Nplate*	☐ Procrit	☐ Promacta	☐ Sancuso	☐ Zofran

Call for ordering procedure

QTY:
DOSING & SIG:

Refill #:_____

Complete this section only if you would like NLSP to initiate a Prior Authorization or Appeal on your behalf:

Previous Therapies

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression	_____
	☐ Finished Therapy	_____
	☐ Toxicity:_____	_____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight _____ kg/lbs Height _____ cm/in BSA _____ m² Additional Comments _____

Allergies _____

Prior Therapies _____ Current Cycle # _____ Total # of Cycles _____

Concomitant Medications _____

Prescriber Information

Physician: _____

Contact Name:_____ Phone #:_____ Fax #: _____ NPI #:_____

Office Address:_____ City:_____ State:_____ Zip:_____

I authorize NLSP and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____