



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: _____

ORAL ONCOLYTICS

<input type="checkbox"/> Afinitor	<input type="checkbox"/> Gleevec	<input type="checkbox"/> Pomalyst**	<input type="checkbox"/> Tamoxifen	<input type="checkbox"/> Xeloda
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Revlimid**	<input type="checkbox"/> Tarceva	<input type="checkbox"/> Xtandi
<input type="checkbox"/> Bosulif	<input type="checkbox"/> Imbruvica	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Tassigna	<input type="checkbox"/> Zolanza
<input type="checkbox"/> Cometriq	<input type="checkbox"/> Inlyta	<input type="checkbox"/> Sutent	<input type="checkbox"/> Temodar	<input type="checkbox"/> _____
<input type="checkbox"/> Erivedge	<input type="checkbox"/> Jakafi	<input type="checkbox"/> Stivarga	<input type="checkbox"/> Thalamid**	
* <input type="checkbox"/> Exjade	<input type="checkbox"/> Mekinist	<input type="checkbox"/> Sylatron	<input type="checkbox"/> Tykerb	
<input type="checkbox"/> Femara	<input type="checkbox"/> Nexavar	<input type="checkbox"/> Tafenlar	<input type="checkbox"/> Votrient	

QTY: _____
DOSING & SIG: _____

Refill #: _____

****Authorization #:** _____

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

Tafinlar _____

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

<input type="checkbox"/> Aranesp	<input type="checkbox"/> Arixtra	<input type="checkbox"/> Caphosol	<input type="checkbox"/> Emend	<input type="checkbox"/> Lovenox	<input type="checkbox"/> Neulasta
<input type="checkbox"/> Neupogen	<input type="checkbox"/> Nplate*	<input type="checkbox"/> Procrit	<input type="checkbox"/> Promacta	<input type="checkbox"/> Sancuso	<input type="checkbox"/> Zofran

QTY: _____
DOSING & SIG: _____

Refill #: _____

**Call for ordering procedure*

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
			<input type="checkbox"/> Disease Progression <input type="checkbox"/> Finished Therapy <input type="checkbox"/> 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 _____

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: _____

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