

**ONCOLOGY**  
Enrollment  
Form

FAX: 1-855-322-2087  
PHONE: 1-855-443-9944  
NPI: 1417216128

Deliver Medications To: Patient's Home Doctor's Office Date Needed By: \_\_\_\_\_ Inj. Training/Admin. Y N

**PATIENT DEMOGRAPHICS**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Prescription Insurance: (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF THE PATIENT'S CARD)  
 Primary Prescription Insurance: \_\_\_\_\_ Rx BIN: \_\_\_\_\_ Rx BIN: \_\_\_\_\_  
 Patient ID/Policy Number: \_\_\_\_\_ Patient Rx Group Number: \_\_\_\_\_

**PATIENT CLINICAL INFORMATION/HISTORY: (PLEASE ATTACH A COPY OF PATIENT'S RECENT CHART NOTES, PATHOLOGY AND LABS)**

Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ BSA: \_\_\_\_\_  
 Drug Allergies: \_\_\_\_\_  
 Patient Height: \_\_\_\_\_ Patient Weight: \_\_\_\_\_  

Previous/Failed Medications	Date and Duration of Therapy	Reason for Discontinuation
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PRESCRIPTION INFORMATION**

DRUG	STRENGTH	INSTRUCTIONS	QUANTITY	REFILLS
<b>NEURO-ONCOLOGY</b>				
Temodar		Take _____ mg by mouth daily for 42 days Take _____ mg by mouth daily at bedtime for 5 days Other: _____		
Gleostine		Take _____ mg by mouth daily for _____ days		
<b>LEUKEMIA</b>				
Sprycel	20mg 50mg 70mg 80mg 100mg 140mg	Take _____ tablet(s) by mouth daily		
Gleevec	100mg 400mg	Take _____ tablet(s) by mouth daily		
Tasigna	150mg 200mg	Take _____ tablet(s) by mouth daily Take _____ tablet(s) by mouth twice daily		
<b>HEMATOPOIETIC STEM CELL</b>				
Neupogen	300mcg PFS 480mcg PFS	Inject _____ mcg sc twice daily for _____ days Inject _____ mcg sc daily for _____ days, then _____ mcg sc twice daily for _____ days Other: _____		
Zarxio	300mcg PFS 480mcg PFS	Inject _____ mcg sc twice daily for _____ days Inject _____ mcg sc daily for _____ days, then _____ mcg sc twice daily for _____ days Other: _____		

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Facility Group or Hospital: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 DEA: \_\_\_\_\_ NPI: \_\_\_\_\_ UPIN: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*By signing I hereby authorize Encompass Rx, LLC and its pharmacists, technicians and other employees and agents to disclose, share and submit patient information to health insurers, HMOs, employer group health plans, governmental health programs, or other payors, for the purposes of satisfying such payor's prior authorization requirements with respect to the medication being prescribed for the treatment of our mutual partners.\*