

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
NEURO-ONCOLOGY				
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		
LEUKEMIA				
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		
HEMATOPOIETIC STEM CELL				
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.