ONCOLOGY Enrollment Form

ENCOMPASS Rx
Leaders In Chronic Disease Management

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: _____