ONCOLOGY Enrollment Form

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."