

ONCOLOGY ENROLLMENT FORM

PATIENT INFORMATION

Name (First, Last):

_____ ☐ Male ☐ Female

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: (____) ____ - ____ Date of Birth (mm/dd/yyyy) : ____ / ____ / ____ Social Security # ____ - ____ - ____

Prescription Information		Strength/ Quantity/Directions(SIG)/Refills
<input type="checkbox"/> Afinitor	<input type="checkbox"/> Ninlaro	
<input type="checkbox"/> Afinitor Disper	<input type="checkbox"/> Perjeta	
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Piqray	
<input type="checkbox"/> Avastin	<input type="checkbox"/> Promacta	
<input type="checkbox"/> Droxia	<input type="checkbox"/> Rydapt	
<input type="checkbox"/> Erleada	<input type="checkbox"/> Rituxan	
<input type="checkbox"/> Erbitux	<input type="checkbox"/> Sylatron	
<input type="checkbox"/> Femara	<input type="checkbox"/> Sprycel	
<input type="checkbox"/> Gleevec	<input type="checkbox"/> Tassigna	
<input type="checkbox"/> Granix	<input type="checkbox"/> Tarceva	
<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Tafinlar	
<input type="checkbox"/> Herceptin	<input type="checkbox"/> Temodar	
<input type="checkbox"/> Jadenu	<input type="checkbox"/> Tykerb	
<input type="checkbox"/> Kisqali	<input type="checkbox"/> Votrient	
<input type="checkbox"/> Leukine	<input type="checkbox"/> Xgeva	
<input type="checkbox"/> Lupron	<input type="checkbox"/> Xeloda	
<input type="checkbox"/> Lovenox	<input type="checkbox"/> Xtandi	
<input type="checkbox"/> Mekinist	<input type="checkbox"/> Zarxio	
<input type="checkbox"/> Neupogen	<input type="checkbox"/> Zykadia	
	<input type="checkbox"/> Zytiga	

Total # of Dangerous Drugs Prescribed _____

DIAGNOSIS AND CLINICAL INFORMATION

<input type="checkbox"/> Diagnosis Description:		ICD-10:
TREATMENT CYCLE:		REST PERIOD:
Height: _____ in/ft	Weight: _____ lb/kg	BSA: _____ m2
Allergies:		<input type="checkbox"/> NKDA
Prior Tried/Failed Medications - MUST provide info to avoid prior authorization denials:		
Medication/Strength	Duration	Reason for Discontinuation



1719 E. Walnut St.
Pasadena, CA 91106
Tel: 626-798-6789
FAX: 626-798-8376

PRESCRIBER'S INFORMATION

Prescriber Name (*First, Last*): _____ **NPI #:** _____

Address: _____ **DEA #:** _____

City: _____ **State:** ____ **Zip Code:** _____

Phone: (____) ____ - ____ **Fax:** (____) ____ - ____ **Contact Name:** _____

Physician Signature: _____ **Date:** ____ / ____ / ____

I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to the disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.