ONCOLOGY ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Renal Dysfunction: ☐ Yes ☐ No

Current SCR: _____ or current GFR: _____mt/min

Liver Dysfunction: ☐ Yes ☐ No

Abnormal Lab Value(s): _____

H/H (Hemoglobin/Hematocrit): _____

Confirmed Mutations: ☐ ALK ☐ BRAF V600E ☐ BRAF V600K ☐ CLL with 17p deletion ☐ PIK3CA ☐ Ph+ ☐ IDH1 ☐ IDH2 ☐ FLT3-ITD

☐ FLT3-TKD ☐ KIT exon11 ☐ KIT exon9 ☐ PDGFRA exon* ____ ☐ EGFR exon* ____ ☐ EGFR p. ____ ☐ Other: _____

*Attach genetic test result to the form

COMPLETE THIS SECTION ONLY IF YOU WOULD LIKE USSC TO INITIATE A PRIOR AUTHORIZATION OR APPEAL ON YOUR BEHALF

PRIOR THERAPY:	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
_____	☐ Disease Progression	_____
_____	☐ Finished Therapy	_____
_____	☐ Toxicity: _____	_____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION

ORAL ONCOLYTICS

☐ Afinitor ____ mg
☐ Afinitor Disperz ____ mg
☐ Cyclophosphamide 25mg cap
☐ Etoposide 50mg cap
☐ Gleevec ____ mg
☐ Kisqali ____ mg
☐ Lomustine ____ mg
☐ Lonsulf ____ mg ____ mg
☐ Mekinist ____ mg
☐ Ninlaro ____ mg
☐ Tarceva ____ mg
☐ Odomzo 200mg cap
☐ Piqray ____ mg
☐ Promacta ____ mg
☐ Purixan ____ mg/ml suspension
☐ Rydapt 25mg cap
☐ Sprycel ____ mg
☐ Tabloid 40mg tab
☐ Tafinlar ____ mg
☐ Targretin ____ mg
☐ Tasigna ____ mg
☐ Temodar ____ mg
☐ Tretinoin 10mg cap
☐ Votrient 200mg tab
☐ Xeloda ____ mg
☐ Zolinza ____ mg
☐ Zytiga ____ mg
☐ Other: _____

QTY: _____
Dosing & Sig: _____
Refill #: _____
**Authorization #: _____

INJECTABLE ONCOLYTICS

☐ Avastin ____ mg/____ ml
☐ Intron A ____ MU powder/vial/pen
☐ Keytruda ____ mg powder, ____ mg/____ ml vial
☐ Lupron depot ____ month ____ mg
☐ Octerotide ____ mcg/____ ml SDV/MDV
☐ Pegasys ____ mg/____ ml PFS/vial/ProClick
☐ Rituxan ____ mg/____ ml vial
☐ Rituxan Hycela ____ mg ____ units/____ ml
☐ Sandostatin LAR Kit ____ mg
☐ Thyrogen (*1.1mg powder)
☐ Zoladex Implant ____ mg

QTY: _____
Dosing & Sig: _____
Refill #: _____
**Authorization #: _____
*only one dosage form is available

SUPPORT DRUGS

☐ Aranesp ____ mcg/____ ml vial/PFS
☐ Arixtra ____ mg/____ ml
☐ Caphosol ____ ml
☐ Emend ____ mg
☐ Epogen ____ units/ml vial
☐ Granix ____ mg/____ ml vial/PFS
☐ Jadenu ____ mg tab
☐ Jadenu Sprinkle ____ mg granules
☐ Leukine ____ mcg powder, ____ mcg/____ ml soln
☐ Lovenox ____ mg/____ ml
☐ Mesna (*1g/10ml)
☐ Neulasta ____ mg/____ ml
☐ Neulasta Onpro (*6mg/0.6ml)
☐ Neupogen ____ mcg/____ ml vial/PFS
☐ Neupogen: ○ Vials ○ Prefilled Syringes
☐ Nivestym ____ mg/____ ml vial/PFS
☐ Prevymis ____ mg tab, ____ mg/____ ml vial
☐ Procrit ____ units/ml vial
☐ Retacrit ____ units/ml vial
☐ Sancuso ____ mg/24hr
☐ Udenyca (*6mg/0.6ml PFS)
☐ Valcyte 450mg tab, 50mg/ml vial
☐ Xgeva (*120mg/1.7ml)
☐ Zarxio ____ mcg/____ ml PFS
☐ Ziextenzo (*6mg/0.6ml PFS)
☐ Zofran ____ mg
☐ Zofran ODT ____ mg
☐ Zometa 4mg powder, ____ mg/____ ml soln
☐ Other: _____

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Patient: _____ DOB: _____

INJECTION TRAINING: **OFFICE TO COORDINATE** **HEALTHDYNE SPECIALTY TO COORDINATE**

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written