Oral Oncology Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

Clinical Information

To expedite prior authorization, please attach current and past treatment regimen(s)/schedule, last clinical office notes, patient current height and weight, and/or lab values/scans.

Diagnosis: _____ **ICD 10 code:** _____
Secondary Diagnosis: _____ **ICD 10 code:** _____
Has patient had prior treatment for this diagnosis? ☐ Yes ☐ No **Desired cycle start date:** _____/_____/_____
Date(s) of previous therapy and medication: _____
Reason(s) for discontinuation: _____

Prescription

Medication		Strength/Directions	Quantity	Refills
❑ Afinitor®	❑ Nilandron			
❑ Alecensa®	❑ Ninlaro®			
❑ Aromasin®	❑ Odomzo®			
❑ Braftovi®	❑ Piqray®			
❑ Brukinsa™	❑ Rydapt®			
❑ Casodex	❑ Soltamox			
❑ Emcyt®	❑ Sprycel®			
❑ Fareston®	❑ Tafinlar®			
❑ Farydak®	❑ Targretin®			
❑ Faslodex®	❑ Tasigna®			
❑ Gleevec®	❑ Temodar®			
❑ Hycamtin®	❑ Tykerb®			
❑ Idhifa®	❑ Xeloda®			
❑ Inrebic®	❑ Xgeva®			
❑ Jadenu®	❑ Vantas			
❑ Kisqali®	❑ Votrient®			
❑ Kisqali Femara® Co-Pack	❑ Yonsa®			
❑ Lupron Depot®	❑ Zoladex®			
❑ Lynparza®	❑ Zolinza®			
❑ Mekinist™	❑ Zykadia®			
❑ Mektovi®	❑ Zytiga®			

Supportive Therapies

Medication		Strength/Directions	Quantity	Refills
❑ Akynzeo®	❑ Neulasta®			
❑ Compazine®	❑ Neupogen®			
❑ Dexamethasone	❑ Prednisone			
❑ Emend Bi-Fold®	❑ Promacta®			
❑ Emend Tri-Fold®	❑ Reglan®			
❑ Exjade®	❑ Udenyca®			
❑ Femara®	❑ Zofran®			
❑ Jadenu®	Other:			
❑ Kytril®	_____			
❑ Mozobil				

Is patient new to this therapy? ☐ YES ☐ NO | **Ship to:** ☐ Patient ☐ Office ☐ Other | **Need by Date:** _____

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ❑ Phone ❑ Fax ❑ Email
Phone: _____ Fax: _____
Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right. ☐