SPECIALTY PHARMACY

ONCOLOGY INFUSION

Irvine, CA **toll free** 855.313.9202 **toll free fax** 844.888.4157
krogerspecialtypharmacy.com

DATE: ______________ NEEDS BY DATE: ______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: ❑ PRESCRIPTION CARD FRONT & BACK ❑ CLINICAL NOTES ❑ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ______________ (ICD-10): ______ Secondary Diagnosis: ______________ (ICD-10): ______

**To expedite Prior Auth services, PLEASE INCLUDE LAB/PATHOLOGY REPORT, PRIOR TREATMENT NOTES, AND CURRENT TREATMENT PLAN.

Drug Allergies ______________ Patient Weight: ______ kg. Patient Height: ______ Body Surface Area: ______

	DOSE/STRENGTH	SIG (Please include cycle)	QUANTITY	REFILLS
❑ ABRAXANE®				
❑ ADCETRIS®				
❑ ALIMTA®				
❑ AVASTIN®				
❑ CARBOPLATIN®				
❑ CISPLATIN®				
❑ DARZALEX®				
❑ DOCETAXEL®				
❑ ELOXATIN®				
❑ ERBITUX®				
❑ GEMCITABINE®				
❑ HERCEPTIN®				
❑ KADCYLA®				
❑ KEYTRUDA®				
❑ KYPROLIS®				
❑ OPDIVO®				
❑ PACLITAXEL®				
❑ RITUXAN®				
❑ TECENTRIQ®				
❑ TORISEL®				
❑ VELCADE®				
❑ VIDAZA®				
❑ YERVOY®				
❑ ZOMETA®				
❑ OTHER				
Pre-Meds:				
❑ DEXAMETHASONE				
❑ DIPHENHYDRAMINE				
❑ RANITIDINE				
❑ ONDANSETRON				
❑ OTHER				

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted ______ Date ______ Prescriber's Signature (no stamps) Dispense As Written ______ Date ______

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