



SPECIALTY PHARMACY

ONCOLOGY INFUSION

Lake Mary, FL toll free

toll free fax

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 | <input type="checkbox"/> Male <input type="checkbox"/> 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 |
|---------------------------------------|----------------------------|----------|---------|
| <input type="checkbox"/> ABRAXANE* | | | |
| <input type="checkbox"/> ADCETRIS* | | | |
| <input type="checkbox"/> ALIMTA* | | | |
| <input type="checkbox"/> AVASTIN* | | | |
| <input type="checkbox"/> CARBOPLATIN* | | | |
| <input type="checkbox"/> CISPLATIN* | | | |
| <input type="checkbox"/> DARZALEX* | | | |
| <input type="checkbox"/> DOCETAXEL* | | | |
| <input type="checkbox"/> ELOXATIN* | | | |
| <input type="checkbox"/> ERBITUX* | | | |
| <input type="checkbox"/> GEMCITABINE* | | | |
| <input type="checkbox"/> HERCEPTIN* | | | |
| <input type="checkbox"/> KADCYLA* | | | |
| <input type="checkbox"/> KEYTRUDA* | | | |
| <input type="checkbox"/> KYPROLIS* | | | |
| <input type="checkbox"/> OPDIVO* | | | |
| <input type="checkbox"/> PACLITAXEL* | | | |
| <input type="checkbox"/> RITUXAN* | | | |
| <input type="checkbox"/> TECENTRIQ* | | | |
| <input type="checkbox"/> TORISEL* | | | |
| <input type="checkbox"/> VELCADE* | | | |
| <input type="checkbox"/> VIDAZA* | | | |
| <input type="checkbox"/> YERVOY* | | | |
| <input type="checkbox"/> ZOMETA* | | | |
| <input type="checkbox"/> OTHER | | | |

| Pre-Meds: | | | |
|--|--|--|--|
| <input type="checkbox"/> DEXAMETHASONE | | | |
| <input type="checkbox"/> DIPHENHYDRAMINE | | | |
| <input type="checkbox"/> RANITIDINE | | | |
| <input type="checkbox"/> ONDANSETRON | | | |
| <input type="checkbox"/> 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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