ONCOLOGY INFUSION

Lake Mary, FL toll free 888.506.2962 toll free fax 888.315.3270
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

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