



SPECIALTY PHARMACY

ORAL AND INJECTABLE ONCOLOGY A-M

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): _____

Drug Allergies: _____

Renal Dysfunction: Yes No Liver Dysfunction: Yes No Serum Creatinine: _____ HgB: _____ HCT: _____

ALK positive testing for Xalkori Date: _____ Date: _____ Date: _____

Confirmed BRAF V600 E Mutation for Tafinlar® or Mekinist Confirmed BRAF V600 K Mutation for Mekinist Previously on Zelboraf Weight: _____

ER: Positive Negative HER2: Positive Negative Metastatic: Yes No Height: _____

To expedite prior authorization services, please attach chemo regimen/schedule, last clinical notes and/or lab values/scans. BSA: _____

DOSE/STRENGTH	SIG (Please include cycle)	QUANTITY	REFILLS
<input type="checkbox"/> Afinitor®	_____	_____	_____
<input type="checkbox"/> Arimidex®	_____	_____	_____
<input type="checkbox"/> Aromasin®	_____	_____	_____
<input type="checkbox"/> Bosulif®	_____	_____	_____
<input type="checkbox"/> Daurismo™	_____	_____	_____
<input type="checkbox"/> Erivedge®	_____	_____	_____
<input type="checkbox"/> Erleada™	_____	_____	_____
<input type="checkbox"/> Femara®	_____	_____	_____
<input type="checkbox"/> Gleevec®	_____	_____	_____
<input type="checkbox"/> Hycamtin®	_____	_____	_____
<input type="checkbox"/> Ibrance®	_____	_____	_____
<input type="checkbox"/> Inlyta®	_____	_____	_____
<input type="checkbox"/> Kisqali®	_____	_____	_____
<input type="checkbox"/> Lorbrena®	_____	_____	_____
<input type="checkbox"/> Mekinist®	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

Ninlaro, Pomalyst, Revlimid, Thalomid Please Use Celgene Form

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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