ORAL AND INJECTABLE ONCOLOGY A-M

SPECIALTY PHARMACY

Lake Mary, FL toll free 888.506.2962 toll free fax 888.315.3270
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): _____

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
❑ Afinitor®				
❑ Arimidex®				
❑ Aromasin®				
❑ Bosulif®				
❑ Daurismo™				
❑ Erivedge®				
❑ Erleada™				
❑ Femara®				
❑ Gleevec®				
❑ Hycamtin®				
❑ Ibrance®				
❑ Inlyta®				
❑ Kisqali®				
❑ Lorbrena®				
❑ Mekinist®				
❑ 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