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 INFORMATION	PRESCRIBER INFORMATION
Patient Name	Prescriber Name
Address	DEA # NPI # License #
City, State, Zip	Address
Main Phone Alternate Phone	City, State, Zip
Social Security #	Phone Fax
Date of Birth ❑ Male ❑ Female	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: ______________ Weight: ______________ ❑ kg ❑ lb Height: ______________ ❑ ft ❑ in Body Surface Area: ______________

	DOSE/STRENGTH	SIG (Please Include Cycle)	QUANTITY	REFILLS
❑ Abraxane®				
❑ Alimta®				
❑ Avastin®				
❑ Besponsa®				
❑ Carboplatin®				
❑ Cisplatin®				
❑ Darzalex®				
❑ Docetaxel®				
❑ Eloxatin®				
❑ Erbitux®				
❑ Gemcitabine®				
❑ Herceptin®				
❑ Kadcyla®				
❑ Keytruda®				
❑ Kyprolis®				
❑ Mylotarg™				
❑ 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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