



SPECIALTY PHARMACY

# ORAL AND INJECTABLE ONCOLOGY A-M

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157

[krogerspecialtypharmacy.com](http://krogerspecialtypharmacy.com)

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE  OTHER \_\_\_\_\_

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFORMATION		
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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