SPECIALTY PHARMACY

MEDICARE PART B ONCOLOGY

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

DATE: ______________ NEEDS BY DATE: ______________

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#	Medicare #	Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

PLEASE FAX COPY OF: ❑ MEDICARE CARD FRONT & BACK ❑ CLINICAL NOTES

CLINICAL INFORMATION

Diagnosis: ______________________ ICD-10: __________ Secondary Diagnosis: ______________________ ICD-10: __________

Weight: ____________ ❑ kg ❑ lb Height: ____________ ❑ cm ❑ in BSA: ____________ m² Metastatic Disease: ❑ Yes ❑ No HER2: ❑ Positive ❑ Negative

Hormone Receptor: ❑ ER Positive ❑ ER Negative ❑ PR Positive ❑ PR Negative Treatment Status: ❑ New to Therapy ❑ Continuation of Therapy, Start Date: ___/___/____

Prior Therapy: ____________________ Length of Treatment: ____________ Reason for Discontinuing: ______________________

Allergies: ❑ NKDA ❑ Other: ____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
must include dose/frequency/cycle on & off days				
❑ Xeloda®	❑ 150mg Tablet ❑ 500mg Tablet	❑ Take ______ mg by mouth every 12 hours for 14 days on, then 7 days off ❑ Conjunction with radiation: Take ______ mg by mouth every 12 hours with radiation for ______ days a week for a total of ______ weeks ❑ Other: ____________________ ____________________ ____________________	____ 150mg tablet(s) ____ 500mg tablet(s)	________ ________
❑ Temodar®	❑ 5mg Capsule ❑ 20mg Capsule ❑ 100mg Capsule ❑ 140mg Capsule ❑ 180mg Capsule ❑ 250mg Capsule	❑ Take ______ mg by mouth once daily for 5 days on, then 23 days off ❑ Conjunction with radiation: Take ______ mg by mouth once daily with radiation for ______ days a week for a total of ______ weeks ❑ Other: ____________________ ____________________ ____________________	____ 5mg capsule(s) ____ 20mg capsule(s) ____ 100mg capsule(s) ____ 140mg capsule(s) ____ 180mg capsule(s) ____ 250mg capsule(s)	________ ________ ________ ________ ________ ________
❑ Other Drug Name: ________ ________ ________	Strength/Formulation: ________ ________ ________	Include Dose/Frequency/Cycle On & Off Days: ____________________ ____________________ ____________________	________ ________ ________	________ ________ ________

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 (stamps/electronic signatures not allowed) Substitution Permitted Date

________________________________ ________
Prescriber's Signature (stamps/electronic signatures not allowed) Dispense As Written Date

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