

# ORAL ONCOLOGY ENROLLMENT FORM

DATE NEEDED: \_\_\_\_\_ MEDICATION/INJECTION START DATE: \_\_\_\_\_

**Walgreens**  
Specialty Pharmacy

Phone: 888.282.5166 Fax: 248.282.0471

## Patient Information

Patient Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Patient's Primary Language: \_\_\_\_\_  
Alternate Contact Name: \_\_\_\_\_  
Alternate Contact Phone: \_\_\_\_\_  
Ship to:  Patient  Physician  Other: \_\_\_\_\_

## Patient Insurance Information

Please copy front and back of medical and pharmacy insurance card and fax to Walgreens Specialty Pharmacy with this form.  Medicare/MedicaidPrimary Insurer: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
Secondary Insurer: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber Name/Date of Birth: \_\_\_\_\_  
Does this Plan Cover Prescription Drugs?:  YES  NO  
Employer: \_\_\_\_\_

## PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize Walgreens Specialty Pharmacy to release any and all information it may have as necessary for Walgreens Specialty Pharmacy to (i) establish my eligibility for benefits; (ii) provide to me products, supplies or services; (iii) receive payment of benefits on my behalf; (iv) communicate with other healthcare providers regarding medical care provided, or to be provided, to me; (v) facilitate the provision of products, supplies, services or training required for my treatment through the product manufacturer, which may be used for promotional programs. I understand that my personal health information is subject to redisclosure. I have the right to revoke this authorization in writing at any time. I also have a right to receive a copy of this authorization. My refusal to sign this authorization will have no impact on receiving treatment from Walgreens Specialty Pharmacy. This authorization is valid for the duration of my treatment with Walgreens Specialty Pharmacy unless revoked in writing.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## Patient Diagnosis Information

Please copy chart notes medication history and baseline lab results and fax to Walgreens Specialty Pharmacy with this form.

Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of weight: \_\_\_\_\_  
Choose one of the following:  New  Restart  Currently on Therapy (Start Date: \_\_\_\_\_) Onset of Illness: \_\_\_\_\_  
Cancer Classification:  Carcinoma  Lymphoma  Sarcoma  Leukemia Stage:  I  II  III  IV  
Previous Treatments: \_\_\_\_\_ Previous Therapy Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_ Discontinuation Reason: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Other Medications Currently Taking: \_\_\_\_\_

## Physician Information

Physician Name: \_\_\_\_\_ Site/Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Specialty: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Fax: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_ Office Contact E-Mail: \_\_\_\_\_  
St. Lic. #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
Office Hours: M - F \_\_\_\_\_ Sat: \_\_\_\_\_ Days Closed: \_\_\_\_\_

## Prescription Information

<input type="checkbox"/> Gleevec® (Imatinib Mesylate)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Nexavar® (Sorafenib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Revlimid® (Lenalidomide)	Strength: _____mg	Qty: _____	Directions: _____	
	RevAssist MD Authorization Number: _____		Patient Risk Category: _____	
	<input type="checkbox"/> Adult-Female Of Child-bearing Age		<input type="checkbox"/> Adult-Female Not of Child-bearing Age	<input type="checkbox"/> Adult Male
	<input type="checkbox"/> Female-Child Of Child-bearing Age		<input type="checkbox"/> Female-Child Not of Child-bearing Age	<input type="checkbox"/> Male Child
<input type="checkbox"/> Sprycel® (Dasatinib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Sutent® (Sunitinib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Tasigna® (Nilotinib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Tarceva® (Erlotinib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Targretin® (Bexarotene)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Temodar® (Temozolomide)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
	Strength: _____mg	Qty: _____	Directions: _____	
	Strength: _____mg	Qty: _____	Directions: _____	
<input type="checkbox"/> Thalomid® (Thalidomide)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Tykerb® (Lapatinib)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
<input type="checkbox"/> Xeloda® (Capecitabine)	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
	Strength: _____mg	Qty: _____	Directions: _____	
Drug: _____	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____
Drug: _____	Strength: _____mg	Qty: _____	Directions: _____	Refill x _____

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must hand write "BRAND NECESSARY" or "BRAND MEDICALLY NECESSARY" in the space below

FOR INTERNAL USE ONLY Name: \_\_\_\_\_ Ext.: \_\_\_\_\_ Date: \_\_\_\_\_ Code: \_\_\_\_\_

**Phone: 888.282.5166**  
**Fax to 4D for Prior Authorization:**  
**Fax: 248.282.0471**