Family PHARMACY • Specialty Care •

# ONCOLOGY SPECIALTY CARE PROGRAM

Phone: **800-545-3653** • Fax: **844-787-1835**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

## 1 PATIENT INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____

DOB: _____ Gender: ❍ M ❍ F Caregiver: _____

Height: _____ Weight: _____ Allergies: _____

## 2 PRESCRIBER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

NPI: _____ DEA: _____

Tax I.D.: _____

Office Contact: _____ Phone: _____

## 3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____

Other: _____ BSA: _____ $m^2$

❑ Adult Female Not of Reproductive Potential

❑ Adult Male Not of Reproductive Potential

| Prior Failed Therapies: | Reason for Discontinuation: | Date: |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

**If Prior Authorization is Denied:** ❑ Automatically Draft Appeal for Review ❑ Send Preferred Formulary Alternatives

## 4 PRESCRIPTION INFORMATION:

| Medication | Dosage & Strength | Direction | QTY | Refills |
|---|---|---|---|---|
| ❑ AFINITOR® | | | | |
| ❑ GLEEVEC® | | | | |
| ❑ HYCAMTIN® | | | | |
| ❑ SPRYCEL® | | | | |
| ❑ TARGRETIN® | | | | |
| ❑ TASIGNA® | | | | |
| ❑ TEMODAR® | | | | |
| ❑ XELODA® | | | | |
| ❑ ZOLINZA® | | | | |
| ❑ OTHER _____ | | | | |

| Supportive Medications | | | Dosage & Direction | QTY | Refills |
|---|---|---|---|---|---|
| ❑ Aranesp® | ❑ Granix™ | ❑ Procrit® | | | |
| ❑ Arixtra® | ❑ Lovenox® | ❑ Promacta® | | | |
| ❑ Caphosol® | ❑ Neulasta® | ❑ Sancuso® | | | |
| ❑ Creon® | ❑ Neupogen® | ❑ Xgeva® | | | |
| ❑ Emend® | ❑ Nplate® | ❑ Zofran® | | | |

## 5 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

## 6 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

## 7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

## 8 PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

**Substitution Permitted** **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.