KINGS PHARMACY

ONCOLOGY ORAL MEDICATIONS ENROLLMENT FORM

Kings Pharmacy 33 Park Avenue Newark, NJ 07104 Phone: 888-644-8633 Fax: 800-922-5150

DATE _____ NEEDS BY DATE _____ SHIP TO ○ Patient ○ Office

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name _____ Date of Birth ____ /____ /____ Sex: ○ Male ○ Female
Address _____ City _____ State _____ Zip _____
Home Phone _____ Alternate Phone _____ Social Security # _____

PRESCRIBER INFORMATION

Prescriber's Name _____ DEA # _____ NPI# _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____

INSURANCE INFORMATION

(Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card Name of Insurer _____ ID# _____ BIN _____ PCN _____ Group _____
Primary Insurance Subscriber _____ ID# _____
Is the Patient eligible for Medicare? ○ Yes ○ No

STATEMENT OF MEDICAL NECESSITY

(Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization)

Diagnosis Description _____ Diagnosis: (ICD-9 code) _____ Date of Diagnosis _____

OTHER CLINICAL INFORMATION/COMMENTS

Weight _____ ○ Kg ○ Lbs Height _____ ○ inches ○ cm BSA _____ m^2
Other Conditions _____
Other Medications _____
Allergies _____ ○ No Known Drug Allergy
Previous Therapies _____

TEST RESULTS		WNL			WNL	
Serum Creatine	_____	○ Yes	○ No	Magnesium _____	○ Yes	○ No
Liver Function	_____	○ Yes	○ No	ECG _____	○ Yes	○ No
Potassium	_____	○ Yes	○ No	baseline BP _____	○ Yes	○ No

PRESCRIPTION INFORMATION

MEDICATIONS

○ Thalomid (R) - STEPS Program Physician Auth # _____ Date _____ ○ MM 203.0

PREGNANCY CATEGORY

○ Adult Female - Childbearing Potential ○ Adult Female - NOT Childbearing Potential ○ Adult Male
○ Female - Childbearing Potential ○ Female - NOT Childbearing Potential ○ Male Child

MEDICATION	DOSE/STRENGTH	SIG.	QTY.
○ Tarceva(R) (Erlotinib HCL)			
○ Thalomid(R) (Thalidomide)			
○ Gleevac(R) (Imatinib mesylate)			
○ Tykerb(R) (lapatinib)			
○ Sprycel(R) (dasatinib)			
○ Tasigna(R) (nilotinib)			
○ Nexavar(R) (sorafenib)			
○ Temodar(R) Capsules (temozolomide)			
○ Xeloda(R) (capecitabine)			

○ Please enroll my patient into the following manufacturer support program: _____

I hereby freely and voluntarily have selected Kings Pharmacy to dispense the medication herin prescribed by my physician.
Patient Signature: _____

PHYSICAN'S SIGNATURE _____

REFILLS

_____ _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)