



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.

Table with 4 columns: Medication, Dose/Strength, Sig., Qty. Rows include Tarceva, Thalomid, Gleevac, Tykerb, Sprycel, Tasigna, Nexavar, Temodar, and Xeloda.

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

I hereby freely and voluntarily have selected Kings Pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature: _____

PHYSICIAN'S SIGNATURE

REFILLS

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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