

**ONCOLOGY SPECIALTY CARE PROGRAM**

Phone: **417-717-0062** • Fax: **888-974-1277**

**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: \_\_\_\_\_  Adult Female Not of Reproductive Potential  
 Other: \_\_\_\_\_ BSA: \_\_\_\_\_ m<sup>2</sup>  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 INJECTION TRAINING:**  Pharmacist to Provide Training  Patient Trained in MD Office  Manufacturer Nurse Support

**5 PRODUCT DELIVERY:**  Patient's Home  Physician's Office  Pharmacy to Coordinate

**6 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**PRESCRIPTION INFORMATION:**

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> AFINITOR®				
<input type="checkbox"/> FEMARA®				
<input type="checkbox"/> GLEEVEC®				
<input type="checkbox"/> HYCAMTIN®				
<input type="checkbox"/> KISQALI®				
<input type="checkbox"/> KISQALI® FEMARA® Co-Pack				
<input type="checkbox"/> RYDAPT®				
<input type="checkbox"/> SPRYCEL®				
<input type="checkbox"/> TARGRETIN®				
<input type="checkbox"/> TASIGNA®				
<input type="checkbox"/> TEMODAR®				
<input type="checkbox"/> XELODA®				
<input type="checkbox"/> ZOLINZA®				
<input type="checkbox"/> ZYTIGA®				
<input type="checkbox"/> OTHER _____				

Supportive Medications	Dosage & Direction	QTY	Refills
<input type="checkbox"/> Aranesp® <input type="checkbox"/> Emend® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Sancuso® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Granix™ <input type="checkbox"/> Nplate® <input type="checkbox"/> Xgeva® <input type="checkbox"/> Caphosol® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Procrit® <input type="checkbox"/> Zofran® <input type="checkbox"/> Creon® <input type="checkbox"/> Neulasta® <input type="checkbox"/> Promacta®			

**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.

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