SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

Oncology Enrollment Form
Patient Information

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed:_____ Rx: ☐ New ☐ Refill _____

Patient Information

Date:_____ Patient SS#: _____ DIAGNOSIS DESCRIPTION: _____ ICD9 CODE: _____

☐ Adult Male ☐ Child Male ☐ Adult Female Not of Reproductive Potential ☐ Adult Female of Reproductive Potential
☐ Female Child Not of Reproductive Potential ☐ Female Child of Reproductive Potential

Patient's First Name: _____ Patient's Last Name: _____

Address:_____ City/County: _____ State: _____ Zip: _____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____

Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)
IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: _____

Prescription

ORAL ONCOLYTICS

☐ Afinitor®	☐ Gleevec®	☐ Pomalyst® **	☐ Tamoxifen	☐ Xeloda®
☐ Arimidex®	☐ Hycamtin®	☐ Revlimid® **	☐ Tarceva®	☐ Xtandi®
☐ Bosulif®	☐ Imbruvica™	☐ Sprycel®	☐ Tasigna®	☐ Zolinza®
☐ Cometriq®	☐ Inlyta®	☐ Sutent®	☐ Temodar®	☐ Zykadia®
☐ Erivedge®	☐ Jakafi®	☐ Stivarga®	☐ Thalomid® **	☐ Zydelig®
☐ Exjade®	☐ Nexavar®	☐ Sylatron®	☐ Tykerb®	☐ _____
☐ Femara®			☐ Votrient®	

QTY:
DOSING & SIG:

Refill #: _____
**Authorization #: _____

☐ Zelboraf® ☐ Tafinlar® BRAF V600E mutation positive melanoma as detected by an FDA-approved test? ☐ Yes ☐ No

☐ Mekinist® BRAF V600E or V600K mutation positive melanoma as detected by an FDA -approved test? ☐ Yes ☐ No

☐ Zytiga® Qty:_____ 250mg 4 QD w/o food Zytiga® Refill #: _____
☐ WITH Prednisone Qty:_____ 5mg BID w/ food Prednisone Refill #: _____

* EXJADE Rxs (Fax ALL EPASS forms to **787-704-2027**)

SUPPORT DRUGS

☐ Aranesp® ☐ Arixtra® ☐ Caphosol® ☐ Emend® ☐ Granix™ ☐ Lovenox® ☐ Neulasta®
☐ Neupogen® ☐ Nplate® * ☐ Procrit® ☐ Promacta® ☐ Sancuso® ☐ Zofran®

QTY:
DOSING & SIG:

*Call for ordering procedure

Refill #: _____

Previous Therapies

Complete this section ONLY if you would like SPS to initiate a Prior Authorization or Appeal on your behalf:

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression	_____
	☐ Finished Therapy	_____
	☐ Toxicity: _____	_____

Prescriber Information

Physician: _____

Contact Name:_____ Phone #:_____ Fax #:_____ NPI #:_____

Office Address:_____ City:_____ State:_____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____