

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

## Oncology Enrollment Form Patient Information

Ship	ip To: 🗌 Patient 🔲 Physician/Clinic Date Shipment Needed: Rx: 🗌 New 🗍 Refill							
Patient Information	Adult Male Child Male Female Child Patient's First Name:	City/County: Work Phone: atient's Weight: Ibs.						
	INSURANCE INFORM	INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK) VAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: ORAL ONCOLYTICS						
		ORAL ONCOLYTICS						
	Afinitor       Gleevec         Arimidex       Hycamtin         Bosulif       Imbruvica™         Cometriq       Inlyta         Erivedge       Jakafi         Exjade       Nexavar	Pomalyst **       Tamoxifen       Xeloda         Revlimid **       Tarceva       Xtandi         Sprycel       Tasigna       Zolinza         Sutent       Temodar       Zykadia         Stivarga       Tykerb       Zydelig         Votrient       Votrient       Note	DOSING & SIG:					
Prescription	Zelboraf       BRAF V600E mutation positive melanoma as detected by an FDA-         Tafinlar       approved test?       Yes       No         Mekinist       BRAF V600E or V600K mutation positive melanoma as detected by an FDA - approved test?       Yes       No		**Authorization #:					
Pr	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 Capl	hosol ☐Emend ☐ Granix™ ☐ Lovenox crit ☐ Promacta ☐ Sancuso ☐ Zofran						
		*Call for ordering procedure	Refill #:					
	Complete this section ONLY if	you would like $SPS$ to initiate a Prior A	e a Prior Authorization or Appeal on your behalf:					
IS BS		REASON FOR DISCONTINUATION OF THE	ERAPY YEAR OF DISCONTINUATION					
Previous Therapies		<ul> <li>Disease Progression</li> <li>Finished Therapy</li> <li>Toxicity:</li></ul>						

Physician:							
Contact Name <u>:</u>	Phone #:	Fax #:	NPI #:				
Office Address: I authorize SPS Specialty Pharm		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:				

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (787) 704-2025 or by emailing info@spscaguas.com is to obtain instructions as to the proper destruction of the transmitted material. Thank you.