Express Health Mart Pharmacy
1173 Nostrand ave,
Brooklyn, NY 11225

Oncology Oral Medications Enrollment Form

Date: ________ Needs by Date: ________

Tel: 347-221-1100
E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com
www.expresshealthmart.com

Ship to: ☐ Patient ☐ Office ☐ Other: ________

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: ________
Address: ________
City, State, Zip: ________
Home Phone: ________
Alternate Phone: ________
Last Four of SS #: ________ Primary Language: ________
Date of Birth: ________ Gender: ________

PRESCRIBER INFORMATION

Prescriber's Name: ________
State License #: ________ UPIN: ________
DEA #: ________ NPI #: ________
Group or Hospital: ________
Address: ________
City, State Zip: ________
Phone: ________ Fax: ________
Contact Person: ________ Phone: ________

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#: ________ Name of Insurer: ________ Phone: ________
Secondary Insurance: Subscriber: ________ ID#: ________ Name of Insurer: ________ Phone: ________
Is the patient eligible for Medicare? ☐ Yes ☐ No

STATEMENT OF MEDICAL NECESSITY

Diagnosis Description: ☐ ________ Diagnosis (ICD-9 code): ________ Date of Diagnosis: ________
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:

Test	Result	WNL	Test	Result	WNL
Serum Creatinine:	________	☐ Yes ☐ No	Magnesium:	________	☐ Yes ☐ No
Liver Function:	________	☐ Yes ☐ No	ECG:	________	☐ Yes ☐ No
Potassium:	________	☐ Yes ☐ No	Baseline BP:	________	☐ Yes ☐ No

$BRAF^{V600E}$ mutation confirmed: ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATIONS

☐ Revlimid REMS™ Program Physician Auth#: ________ Date: ________ Revlimid Diagnosis: ☐ MDS 238.7
☐ Pomalyst REMS™ Program Physician Auth#: ________ Date: ________ ☐ MM 203.0
☐ Thalomid REMS ™ Program Physician Auth#: ________ Date: ________ ☐ MCL 200.4

Pregnancy Category:
☐ Adult Female – Reproductive Potential ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Male
☐ Female Child – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Male Child

☐ Afinitor (everolimus)	☐ Afinitor Disperz (everlolimus)	☐ Bosulif® (bosutinib)	☐ Erivedge™ (vismodegib)
☐ Gleevec® (imatinib mesylate)	☐ Hycamtin Capsules® (topotecan)	☐ Iclusig™ (ponatinib)	☐ Inlyta® (axitinib)
☐ Jakafi™ (ruxolitinib)	☐ Mekinist™ (trametinib)	☐ Nexavar® (sorafenib)	☐ Pomalyst® (pomalidomide)
☐ Revlimid® (lenalidomide)	☐ Sprycel™ (dasatinib)	☐ Stivarga® (regorafenib)	☐ Sutent® (sunitinib malate)
☐ Tafinlar™ (dabrafinib)	☐ Tarceva™ (erlotinib HCL)	☐ Targretin Capsules (bexarotene)	☐ Tasigna® (nilotinib)
☐ Temodar® Capsules (temozolomide)	☐ Thalomid® (thalidomide)	☐ Tykerb® (lapatinib)	☐ Votrient® (pazopanib)
☐ Xalkori® (crizotinib)	☐ Xeloda® (capecitabine)	☐ Xtandi® (enzalutamide)	☐ Zelboraf® (vemurafenib)
☐ Zolinza® (vorinostat)	☐ Zytiga™ (abiraterone)	☐ Other: ________	

STRENGTH	SIG./DIRECTIONS

Refills: **Quantity:**

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

Physician's Signature

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

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Oncology Orals 101813