Oncology Oral Medications Hematologic Malignancies Enrollment Form

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

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

6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

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

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐Office ☐ Other: _____
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:

		WNL			WNL
Serum Creatinine:	_____	☐ Yes ☐ No	ECG:	_____	☐ Yes ☐ No
Liver Function:	_____	☐ Yes ☐ No	Baseline BP:	_____	☐ Yes ☐ No

5 PRESCRIPTION INFORMATION

MEDICATIONS

☐ Revlimid REMS™ Program Physician Auth#: _____ Date: _____ 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

☐ Bosulif® (bosutinib) ☐ Iclusig™ (ponatinib) ☐ Jakafi™ (ruxolitinib) ☐ Gleevec® (imatinib mesylate)
☐ Pomalyst® (pomalidomide) ☐ Revlimid® (lenalidomide) ☐ Sprycel™ (dasatinib) ☐ Targretin Capsules (bexarotene)
☐ Tasigna® (nilotinib) ☐ Thalomid® (thalidomide) ☐ Zolinza® (vorinostat)
☐ Other: _____

STRENGTH	SIG./DIRECTIONS
Refills:	Quantity:

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

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