

Oncology Oral Medications Hematologic Malignancies Enrollment Form

 **Express Health Mart Pharmacy**
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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: _____ m²
Other Conditions: _____
Other Medications: _____
Allergies: _____ No Known Drug Allergy
Previous Therapies: _____

Test Results:

	WNL		WNL
Serum Creatinine: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	ECG: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Function: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Baseline BP: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

5 PRESCRIPTION INFORMATION

MEDICATIONS

<input type="checkbox"/> Revlimid REMS™ Program	Physician Auth#: _____	Date: _____	Diagnosis: <input type="checkbox"/> MDS 238.7
<input type="checkbox"/> Pomalyst REMS™ Program	Physician Auth#: _____	Date: _____	<input type="checkbox"/> MM 203.0
<input type="checkbox"/> Thalomid REMS™ Program	Physician Auth#: _____	Date: _____	<input type="checkbox"/> MCL 200.4

Pregnancy Category:

<input type="checkbox"/> Adult Female – Reproductive Potential	<input type="checkbox"/> Adult Female – NOT of Reproductive Potential	<input type="checkbox"/> Adult Male
<input type="checkbox"/> Female Child – Reproductive Potential	<input type="checkbox"/> Female Child – NOT of Reproductive Potential	<input type="checkbox"/> Male Child

<input type="checkbox"/> Bosulif® (bosutinib)	<input type="checkbox"/> Iclusig™ (ponatinib)	<input type="checkbox"/> Jakafi™ (ruxolitinib)	<input type="checkbox"/> Gleevec® (imatinib mesylate)
<input type="checkbox"/> Pomalyst® (pomalidomide)	<input type="checkbox"/> Revlimid® (lenalidomide)	<input type="checkbox"/> Sprycel™ (dasatinib)	<input type="checkbox"/> Targetin Capsules (bexarotene)
<input type="checkbox"/> Tassigna® (nilotinib)	<input type="checkbox"/> Thalomid® (thalidomide)	<input type="checkbox"/> Zolanza® (vorinostat)	
<input type="checkbox"/> Other: _____			

STRENGTH

SIG./DIRECTIONS

Refills: _____ Quantity: _____

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 X **PHYSICIAN SIGNATURE REQUIRED** X
DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

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