



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

**Oncology Oral Medications  
Solid Tumors  
Enrollment Form**

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

Date: \_\_\_\_\_ Needs by Date: \_\_\_\_\_

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<sup>2</sup>  
Other Conditions: \_\_\_\_\_  
Other Medications: \_\_\_\_\_  
Allergies: \_\_\_\_\_  No Known Drug Allergy  
Previous Therapies: \_\_\_\_\_

**Test Results:** \_\_\_\_\_

Serum Creatinine: \_\_\_\_\_ WNL  Yes  No Magnesium: \_\_\_\_\_ WNL  Yes  No BRAF<sup>V600E</sup> mutation confirmed:  Yes  No  
Liver Function: \_\_\_\_\_  Yes  No ECG: \_\_\_\_\_  Yes  No  
Potassium: \_\_\_\_\_  Yes  No Baseline BP: \_\_\_\_\_  Yes  No

**PRESCRIPTION INFORMATION**

**MEDICATIONS**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Afinitor (everolimus)                        | <input type="checkbox"/> Afinitor Disperz (everolimus)          | <input type="checkbox"/> Bosulif <sup>®</sup> (bosutinib)    | <input type="checkbox"/> Erivedge <sup>™</sup> (vismodegib)   |
| <input type="checkbox"/> Hycamtin Capsules <sup>®</sup> (topotecan)   | <input type="checkbox"/> Inlyta <sup>®</sup> (axitinib)         | <input type="checkbox"/> Mekinist <sup>™</sup> (trametinib)  | <input type="checkbox"/> Nexavar <sup>®</sup> (sorafenib)     |
| <input type="checkbox"/> Stivarga <sup>®</sup> (regorafenib)          | <input type="checkbox"/> Sutent <sup>®</sup> (sunitinib malate) | <input type="checkbox"/> Tafinlar <sup>™</sup> (dabrafenib)  | <input type="checkbox"/> Tarceva <sup>™</sup> (erlotinib HCL) |
| <input type="checkbox"/> Temodar <sup>®</sup> Capsules (temozolomide) | <input type="checkbox"/> Tykerb <sup>®</sup> (lapatinib)        | <input type="checkbox"/> Votrient <sup>®</sup> (pazopanib)   | <input type="checkbox"/> Xalkori <sup>®</sup> (crizotinib)    |
| <input type="checkbox"/> Xeloda <sup>®</sup> (capecitabine)           | <input type="checkbox"/> Xtandi <sup>®</sup> (enzalutamide)     | <input type="checkbox"/> Zelboraf <sup>®</sup> (vemurafenib) | <input type="checkbox"/> Zytiga <sup>™</sup> (abiraterone)    |
| <input type="checkbox"/> Other: _____                                 |   |  |   |

**STRENGTH**

**SIG./DIRECTIONS**

|  |  |
|--|--|
|  |  |
|--|--|

Refills: \_\_\_\_\_ Quantity: \_\_\_\_\_

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

**Physician's Signature**

X   
PRODUCT SUBSTITUTION PERMITTED (Date)

X   
DISPENSE AS WRITTEN (Date)

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 Solid Tumors 070313