BLUEGRASS PHARMACY | ONCOLOGY ORAL MEDICATIONS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

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

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

ICD-10 Code	Description

Height (in/cm): _____ Weight (lb/kg): _____ BSA (m²): _____

Pregnancy Category:

◯ Adult female of childbearing potential
◯ Adult female **not** of childbearing potential
◯ Female child of childbearing potential
◯ Female child **not** of childbearing potential
◯ Adult male
◯ Male child

Allergies:

Other Conditions:

Other Medications:

Previous Therapies:

5. PRESCRIPTION INFORMATION

Medication	Dose	Directions	Qty	Refills	Medication	Dose	Directions	Qty	Refills
◯ Afinitor® (everolimus)					◯ Purixan (mercaptopurine)				
◯ Afinitor Disperz					◯ Revlimid® (lenalidomide) **(LD)***				
◯ Alecensa (alectinib)					◯ Sprycel™ (dasatinib)				
◯ Bosulif® (bosutinib) **(LD)***					◯ Stivarga® (regorafenib) **(LD)***				
◯ Cabometyx (cabozantinib) **(LD)***					◯ Sutent® (sunitib malate) **(LD)***				
◯ Cotellic (cobimetinib)					◯ Tafinlar™ (dabrafenib)				
◯ Erivedge™ (vismodegib)					◯ Tagrisso (osimertinib)				
◯ Farydak (panobinostat) **(LD)***					◯ Tarceva™ (erlotinib)				
◯ Gleevec® (imatinib mesylate)					◯ Targretin® (bexarotene) capsules				
◯ Hycamtin® (topotecan HCl)					◯ Tasigna® (nilotinib)				
◯ Ibrance (palbociclib) **(LD)***					◯ Temodar® (temozolomide) capsules				
◯ Iclusig™ (ponatinib) **(LD)***					◯ Thalomid® (thalidomide) **(LD)***				
◯ Inlyta® (axitinib) **(LD)***					◯ Tykerb® (lapatinib)				
◯ Iressa (genfitinib)					◯ Votrient® (pazopanib)				
◯ Jakafi™ (ruxolitinib) **(LD)***					◯ Xalkori® (crizotinib) **(LD)***				
◯ Lonsurf (trifluridine & tipiracil) **(LD)***					◯ Xeloda® (capecitabine)				
◯ Mekinist™ (trametinib)					◯ Xtandi® (enzalutamide)				
◯ Nexavar® (sorafenib) **(LD)***					◯ Zelboraf® (vemurafenib)				
◯ Ninlaro (ixazomib)					◯ Zolinza® (vorinostat)				
◯ Odomzo (sonidegib) **(LD)***					◯ Zykadia™ (ceritinib)				
◯ Pomalyst® (pomalidomide) **(LD)***					◯ Zytiga™ (abiraterone)				

(LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information.

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED 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 or 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.