SUPERIOR SPECIALTY PHARMACY
Transforming lives one patient at a time

ONCOLOGY ENROLLMENT FORM
Patient Information

Phone: 813-960-2020
Fax: 813-549-3810
Toll Free: 877-436-2020

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed: _____ Rx: ☐ New ☐ Refill _____

Patient Information

Date: _____ Patient SS#: _____ Diagnosis Description: _____ ICD9 Code: _____

☐ Adult Male ☐ Child Male ☐ Adult Female Not of Reproductive Potential ☐ Adult Female of Reproductive Potential
☐ Female Child Not of Reproductive Potential ☐ Female Child of Reproductive Potential

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City/County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____

Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (BOTH FRONT & BACK)
IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: _____

Prescription

ORAL ONCOLYTICS

☐ Afinitor	☐ Gleevec	☐ Pomalyst**	☐ Tamoxifen	☐ Xeloda	QTY:
☐ Arimidex	☐ Hycamtin	☐ Revlimid**	☐ Tarceva	☐ Xtandi	DOSING & SIG:
☐ Bosulif	☐ Iclusig	☐ Sprycel	☐ Tasigna	☐ Zolinza	
☐ Cometriq	☐ Inlyta	☐ Sutent	☐ Temodar	☐ _____	
☐ Erivedge	☐ Jakafi	☐ Stivarga	☐ Thalomid**		
* Exjade	☐ Mekinist	☐ Sylatron	☐ Tykerb		
☐ Femara	☐ Nexavar	☐ Tafinlar	☐ Votrient		Refill #: _____

☐ Zelboraf BRAF V600E mutation positive as detected by an FDA-approved test? ☐ Yes ☐ No

**Authorization #: _____

☐ Zytiga Qty: _____ 250mg 4 QD w/o food Zytiga Refill #: _____

☐ WITH Prednisone Qty: _____ 5mg BID w/ food Prednisone Refill #: _____

* EXJADE Rxs (Fax ALL EPASS forms to 813.549.3810)

SUPPORT DRUGS

☐ Aranesp ☐ Arixtra ☐ Caphosol ☐ Emend ☐ Lovenox ☐ Neulasta
☐ Neupogen ☐ Nplate* ☐ Procrit ☐ Promacta ☐ Sancuso ☐ Zofran

QTY:
DOSING & SIG:

*Call for ordering procedure

Refill #: _____

Complete this section ONLY if you would like Superior Specialty Pharmacy to initiate a Prior Authorization or Appeal on your behalf:

Previous Therapies

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression	_____
	☐ Finished Therapy	_____
	☐ Toxicity: _____	_____

Prescriber Information

Physician: _____

_____

Contact Name: _____ Phone #: _____ Fax #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize Superior Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature: _____ DEA #: _____ Date: _____