elixir
SPECIALTY PHARMACY

Oncology Enrollment Form

Fax: 877-309-0687 Phone: 877-437-9012

☐ New to Therapy
☐ Current Therapy

Customer Information

Customer Name: _____
Date of Birth: _____ Gender: M or F Caretaker: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____
Please attach copy of front and back of customer's prescription insurance card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder: _____
Policy holder Employer: _____
Relationship to Customer: _____
ID# _____ Group# _____
Pharmacy Benefit Information:
RxBIN: _____ RxPCN: _____

Prescriber Information

Practice/ Organization Name: _____
Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____
DEA# _____ NPI# _____
License#: _____ Medicaid UPIN#: _____
Physician Specialty: _____
Office Contact: _____
Office Contact Phone#: _____

Clinical Information and Prescription

Primary Diagnosis
ICD-10 Code: _____ Description: _____
_____ _____
_____ _____

Cancer Stage: ☐ Stage 0 ☐ Stage I ☐Stage II ☐Stage III ☐Stage IV ☐ Other: _____
Has the patient been treated previously for this condition: ☐ No ☐ Yes
Previous Medications: _____
Is the patient currently on other chemotherapeutic medications? : ☐ No ☐ Yes:
Concurrent Medications: _____
Patient Height: _____ cm/Inches Patient Weight: _____ kg/lbs. BSA: _____ m^2
Date Taken: _____
First Cycle Start Date: _____ Current Cycle Start Date: _____ Cycle Length: _____
Allergies: _____
Current Medications: _____
Co-Morbidities: _____

℞

Drug	Dose	Directions / Frequency	Hold for Labs (Y/N)	Quantity Prescribed	Refills Allowed

Pre-Chemo Orders and Special Instructions	Post-Chemo Orders and Special Instructions

Date Shipment Needed: _____ **Ship to:** ☐ Patient ☐ Prescriber ☐ Infusion Clinic
Shipment Address: _____ Attn: _____
City: _____ State: _____ Zip: _____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

X _____ **Date:** _____
Physician Signature (no stamps)
If physician requests Brand Name only, DAW MUST be HANDWRITTEN in the following space provided: