elixir
SPECIALTY PHARMACY

Oncology Oral Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ New to Therapy
☐ Current Therapy

Patient Information

Patient Name: _____
Date of Birth: _____ Gender: _____ SS#_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Patient Weight: _____☐ ☐ kg/ lbs Patient Height: _____☐ ☐ in/ cm

Please attach copy of front and back of patient's prescription ins. card(s) if applicable

Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Prescriber Information

Practice/Organization Name: _____
Prescriber Name: _____
Contact Person: _____ Contact's Phone: _____
Address:_____ _____
City: _____ State: _____ Zip: _____
Office Phone#:_____ Office Fax#:_____
DEA#_____ NPI#_____
License#:_____ Medicaid UPIN#:_____
Physician Specialty: _____
Date Shipment Needed: _____
Ship to: ☐**Patient** ☐**Prescriber** ☐**Other**_____
Shipment Address: _____ Attn: _____
City: _____State: _____Zip:_____

If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

Diagnosis and Clinical Information

Diagnosis (ICD-10):_____ Description:_____
Date of Diagnosis or Years with Disease: _____
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:_____
Patients Allergies: _____ Latex allergy: ☐Yes ☐No
First Cycle Start Date:_____ Current Cycle Start Date:_____ Cycle Length:_____
Current Medications:_____
Comorbidities:_____
Shipment to Patient ☐ Yes ☐ No Shipment to Provider: ☐ Yes ☐ No Shipment Address: _____

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Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Phone:** _____ **Date:** _____

Prescriber Address: _____

Medication:

☐Afinitor (everolimus)	☐Ibrance (palbociclib)	☐Mektovi (binimetinib)	☐Sprycel (dasatinib)	☐Tykerb (lapatinib)
☐Afinitor Disperz (everolimus)	☐Idhifa (enasidenib)	☐Nexavar (sorafenib)	☐Sutent (sunitinib malate)	☐Votrient (pazopanib)
☐Alecensa (alectinib)	☐Inlyta (axitinib)	☐Odomzo (sonidegib)	☐Tabrecta (capmatinib)	☐Xalkori (crizotinib)
☐Bosulif (bosutinib)	☐Inrebic (fedratinib)	☐Onureg (azacitidine)	☐Tafinlar (dabrafinib)	☐Xeloda (capecitabine)
☐Braftovi (encorafenib)	☐Iressa (gefitinib)	☐Piqray (alpelisib)	☐Talzenna (talazoparib)	☐Yonsa (abiraterone acetate)
☐Cytoxan (cyclophosphamide)	☐Kisqali (ribociclib)	☐Purixan (mercaptopurine)	☐Tarceva (erlotinib)	☐Zolinza (vorinostat)
☐Erivedge (vismodegib)	☐Lenvima (Lenvatinib)	☐Rozlytrek (entrectinib)	☐Targretin (bexarotene)	☐Zykadia (ceritinib)
☐Gleevec (imatinib mesylate)	☐Lorbrena (lorlatinib)	☐Rydapt (midostaurin)	☐Tasigna (nilotinib)	☐Zytiga (abiraterone)
☐Gleostine (lomustine)	☐Mekinist (trametinib)	☐Scemblix (asciminib)	☐Temodar (temozolomide)	☐Other:_____

Drug	Dose	Directions/Frequency	Hold for Labs (Y/N)	Quantity Prescribed	Refills Allowed
Pre-Chemo Orders/Special Instructions:			**Post-Chemo Orders/Special Instructions:**		

☐Anastrozole ☐Letrozole
☐Dexamethasone ☐Prednisone
☐Exemastane ☐Zoladex
☐Fulvestrant

X _____ **Date:** _____
Physician Signature (no stamps)

If Brand required "Dispense as Written" must be hand written in box