Medley Pharmacy
Sinks Pharmacy
Towne Pharmacy
Steelville Drug
SpecialtyCARE Services

ONCOLOGY SPECIALTY CARE PROGRAM

Phone: **844-422-6400** • Fax: **888-850-4018**

KLOUDSCRIPT
Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
Other: _____ BSA: _____ m^2

❑ Adult Female Not of Reproductive Potential
❑ Adult Male Not of Reproductive Potential

Prior Failed Therapies:	Reason for Discontinuation:	Date:
1.		
2.		
3.		
4.		

If Prior Authorization is Denied: ❑ Automatically Draft Appeal for Review ❑ Send Formulary Preferred Alternatives

4 PRESCRIPTION INFORMATION:

Medication	Dosage & Strength	Direction	QTY	Refills
❑ AFINITOR ®				
❑ GLEEVEC ®				
❑ HYCAMTIN ®				
❑ SPRYCEL ®				
❑ TARGRETIN ®				
❑ TASIGNA ®				
❑ TEMODAR ®				
❑ XELODA ®				
❑ ZOLINZA ®				
❑ OTHER _____				

Supportive Medications			Dosage & Direction	QTY	Refills
❑ Aranesp®	❑ Granix™	❑ Procrit®			
❑ Arixtra®	❑ Lovenox®	❑ Promacta®			
❑ Caphosol®	❑ Neulasta®	❑ Sancuso®			
❑ Creon®	❑ Neupogen®	❑ Xgeva®			
❑ Emend®	❑ Nplate®	❑ Zofran®			

5 INJECTION TRAINING:

❍ To Be Administered by Pharmacist ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

6 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

7 INSURANCE INFORMATION:

Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE:

I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____
Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.