Medley Pharmacy
Sinks Pharmacy
Towne Pharmacy
Steelville Drug
Specialty CARE 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: ________ m²

❑ 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 Preferred Formulary Alternatives

4 INJECTION TRAINING:

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

5 PICK UP OR DELIVERY:

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

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

7 PRESCRIPTION INFORMATION:

Patient Name: ______________________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ **CYTOXAN®**				
❑ **MEKINIST®**				
❑ **PROMACTA®**				
❑ **REVLIMID®**				
❑ **TAFINLAR®**				
❑ **TYKERB®**				
❑ **VOTRIENT®**				
❑				
❑				
❑ OTHER ________				

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

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: ________
Substitution Permitted

Signature: ______________ Date: ________
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.

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