Lumicera Health Services

Oral Oncology Enrollment Form

310 Integrity Drive Madison, WI 53717 / 5350 E High St, Ste 200, Phoenix, AZ 85054 | Phone: 1(855) 847-3553 / Fax: 1(855) 847-3558

Ship to: ☐ Patient ☐ Clinic ☐ Other Date: Needs By Date:

PATIENT INFORMATION

Patient Name _____
Address _____
City, State, Zip _____
Email _____ Language _____
DOB (mm/dd/yyyy) _____ Gender ☐ Female ☐ Male
Preferred Phone _____ Phone Type ☐ Cell ☐ Home ☐ Work
Alternate Phone _____ Phone Type ☐ Cell ☐ Home ☐ Work
Emergency Contact Person _____ Relation To Patient_____
Emergency Contact Person Phone _____

PRESCRIBER INFORMATION

Prescriber Name _____Specialty_____
DEA _____NPI_____
Facility Name _____
Address _____
City, State, Zip_____
Phone _____ Fax _____
Office Contact _____ Phone_____

INSURANCE INFORMATION *Please fax FRONT and BACK copy of all insurance cards (Prescription and Medical)*

CLINICAL INFORMATION *Please fax a list of current medications and OTCs for patient*

Diagnosis (*Please include diagnosis name & ICD-10)* Date of Diagnosis:_____
Diagnosis_____ ICD-10_____
Weight: _____ Height _____ or BSA: _____
Allergies/Reaction: ☐ NKDA ☐ Other:
_____
Is the patient pregnant, nursing, or planning a pregnancy? ☐ Yes ☐ No ☐ N/A
Patient receiving concomitant radiation? ☐ Yes ☐ No

Therapy: ☐ New ☐ Continuing Therapy ☐ Restart
Patient has been previously been treated for this condition: ☐ Yes ☐ No
If yes, please list previous medications:
_____
Cycle length (if applicable): _____
Additional Comments:

PRESCRIPTION INFORMATION (generic will be substituted when available unless otherwise specified)

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Afinitor® (everolimus)	☐ 2.5 mg ☐ 2 mg Disperz™ ☐ 5 mg ☐ 3 mg Disperz™ ☐ 7.5 mg ☐ 5 mg Disperz™ ☐ 10 mg	☐ Take _____mg by mouth _____ daily		
☐ Gleevec® (imatinib)	☐ 100 mg ☐ 400 mg	☐ Take _____mg by mouth _____ daily with food		
☐ Kisqali® (ribociclib)	☐ 200 mg dose + ☐Femara 2.5mg ☐ 400 mg dose + ☐Femara 2.5mg ☐ 600 mg dose + ☐Femara 2.5mg	☐ Take _____mg by mouth once daily for 21 days on then 7 days off		
☐ Mekinist® (trametinib)	☐ 0.5 mg ☐ 2 mg	☐ Take _____mg by mouth once daily on an empty stomach (at least 1 hour before or 2 hours after a meal)		
☐ Sprycel® (dasatinib)	☐ 20 mg ☐ 80 mg ☐ 50 mg ☐ 100 mg ☐ 70 mg ☐ 140 mg	☐ Take _____mg by mouth _____ daily		
☐ Tafinlar® (dabrafenib)	☐ 50 mg ☐ 75 mg	☐ Take _____mg by mouth twice daily on an empty stomach (at least 1 hour before or 2 hours after a meal)		
☐ Tarceva® (erlotinib)	☐ 25 mg ☐ 100 mg ☐ 150 mg	☐ Take _____mg by mouth once daily on an empty stomach (at least 1 hour before or 2 hours after a meal)		
☐ Targretin® (bexarotene) ☐ Targretin® gel	☐ 75 mg ☐ 1% 60gm tube	☐ Take _____mg by mouth once daily with food ☐ Apply to lesions _____ times per day		
☐ Tasigna® (nilotinib)	☐ 50 mg ☐ 150 mg ☐ 200 mg	☐ Take _____mg by mouth twice daily on an empty stomach (at least 1 hour before or 2 hours after a meal)		
☐ Temodar® (temozolomide)	☐ 5 mg ☐ 140 mg ☐ 20 mg ☐ 180 mg ☐ 100 mg ☐ 250 mg	☐ Take _____mg by mouth once daily for 5 days of a 28 day cycle ☐ Take _____mg by mouth once daily for _____ days during radiation ☐ Other:		
☐ Toposar® (etoposide)	☐ 50 mg	☐ Take _____mg by mouth _____ daily for _____ days ☐ Other:		
☐ Tykerb® (lapatinib)	☐ 250 mg	☐ Take _____mg by mouth _____ daily on an empty stomach (at least 1 hour before or 1 hour after a meal)		
☐ Votrient® (pazopanib)	☐ 200 mg	☐ Take _____mg by mouth once daily on an empty stomach (at least 1 hour before or 2 hours after a meal)		
☐ Xeloda® (capecitabine)	☐ 150 mg ☐ 500 mg	☐ Take _____mg by mouth in the morning and take _____mg by mouth in the evening for _____ days on and _____ days off ☐ Other:		
☐ Zykadia® (ceritinib)	☐ 150 mg	☐ Take _____mg by mouth once daily with food		
☐ Zytiga® (abiraterone) ☐ prednisone	☐ 150 mg ☐ 500 mg ☐ 5 mg	☐ Take _____mg by mouth once daily on an empty stomach (at least 1 hour before or 2 hours after a meal) ☐ Take 5 mg by mouth _____ daily with food		
☐ Other				

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ _____ _____

PRODUCT SUBSTITUTION PERMITTED *Date* *DISPENSE AS WRITTEN*