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Specialty Pharmacy Services
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Patient Intake Form-ONCOLOGY

3796 Howell Branch Road • Winter Park, FL 32792
Toll free: 866-699-8239 • Toll free fax 866-495-3304

TODAY'S DATE____________ DATE NEEDED____________

PATIENT INFORMATION

First:	Last:	M.I.:	
Date of Birth:	SSN:	☐Male ☐ Female	
Best Phone:	Alt. Phone:	Email:	
Address:	City:	State:	Zip:

PRESCRIBER INFORMATION

First:	Last:	M.I.:	
DEA#:	Med. Lic. #:	NPI#:	
Office Contact:	Phone:	Alt. Phone:	
Address:	City:	State:	Zip:

INSURANCE INFORMATION (PLEASE FAX COPIES OF FRONT AND BACK OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS)

Primary:	PCN:	BIN#	**Secondary:**	PCN:	ID#:
Phone:	ID#:	Group#	Phone:	BIN#	Group#
Prescription Drug Insurer:	Phone:		RxGrp#:	RxBIN#:	PCN/ID#:

CLINIC INFORMATION

Diagnosis:	ICD-9:	Diagnosis Date:	
Lab Values: WBC_______ ANC_______ Hgb_______ Hct_______ Plate_______ BSA_______		Height:	Weight:
Medical Justification (Failed Medications, Allergies, etc.):			
Current Therapies/Medications including OTC:			
Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No		If yes, what is the washout period?	

☑ PRESCRIPTION (PLEASE SELECT FROM THE BELOW AND PROVIDE APPROXIMATE DAYS SUPPLY)

DRUG NAME	PRESCRIPTION ORDERS	QUANTITY	REFILLS
Xeloda			
Tarceva			
Temodar			
Gleevec			
Afinitor			
Sutent			
Thalomid			
Tasigna			
Zofran/Ondansetron			
Emend			
Kytril/Graniseton			
Anzemet/Dolasetron			

MUCOSITIS

DRUG NAME	PRESCRIPTION ORDERS	QUANTITY	REFILLS
Episil	1-3 applications 2-3x Daily or PRN	#4 x 10mL	
MuGuard	5-10 ml Swish and expel or swallow 4-6 times daily or as prescribed	_____6pk(s) (8 oz bottles)	
Magic MouthWash ☐ Add Lidocaine	Swish, gargle, and spit one to two teaspoonfuls every six hours as needed. May be swallowed if esophageal involvement.	________	

ADDITIONAL INSTRUCTIONS

Please Deliver To: ☐ Patient's Home ☐ Dr.'s Office ☐ 1st dose to MD's office, remaining refills to patient's home

Physician's Signature:	Date: