ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY
www.acropharmacy.com

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ONCOLOGYASSIST® ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 12.04.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY
www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
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NPI: 1598762015

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:_____ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) ☐Patient Address ☐Always to Physicians Office ☐First fill to Physician's Office, refills to Patient Address

Diagnostic Information: Diagnosis/ICD-10-CM Codes ☐_____ ☐_____ ☐_____ Date of Diagnosis: _____ OR Years with Disease:_____

Requested Clinical Information *(as applicable - please send clinical notes)*
Height: _____ Weight: _____ BSA: _____m^2
Cancer Stage: ☐Localized ☐Stage I ☐Stage II ☐Stage III ☐Stage IV ☐Other _____
Confirmed Mutations: ☐EGFR ☐KRAS ☐ALK ☐ROS1 ☐T790M ☐BRAF V600E ☐BRAF V600K ☐gBRCAm

Previous Therapies: Has patient been treated previously for this condition?
☐ Yes ☐ No (If yes, List Medications) _____
_____

Ia. Oncology Medications:

☐Afinitor® (everolimus)	☐Arimidex® (anastrozole)	☐Aromasin® (exemestane)	☐Bosulif® (bosutinib)
☐Cotellic® (cobimetinib)	☐Cytoxan®(cyclophosphamide)	☐Daurismo™ (glasdegib)	☐Erleada™ (apalutamide)
☐Erivedge® (vismodegib)	☐Femara® (letrozole)	☐Gleevec® (imatinib)	☐Gleostine® (lomustine)
☐Hycamtin® (topotecan)	☐Ibrance® (palbociclib)	☐Inlyta® (axitinib)	☐Kisqali® (ribociclib)
☐Lorbrena® (lorlatinib)	☐Mekinist® (trametinib)	☐Ninlaro® (ixazomib)	☐Odomzo® (sonidegib)
☐Rydapt® (midostaurin)	☐Sprycel® (dasatinib)	☐Sutent® (sunitinib)	☐Tafinlar® (dabrafinib)
☐Talzenna™ (talazoparib)	☐Tarceva® (erlotinib HCL)	☐Targretin® (bexarotene)	☐Tasigna® (nilotinib)
☐Temodar® (temozolomide)	☐Tykerb® (lapatinib)	☐Vepesid® (etoposide)	☐Vizimpro® (dacomitinib)
☐Votrient® (pazopanib)	☐Xalkori® (crizotinib)	☐Xeloda® (capecitabine)	☐Xtandi® (enzalutamide)
☐Zelboraf® (vemurafenib)	☐Zolinza® (vorinostat)	☐Zytiga®(abiraterone) ☐*with Prednisone*	☐Other:_____

Dose & Directions *(please specify chemotherapy cycle days on / days off where applicable)*

QUANTITY

REFILLS

Ib. Celgene REMS Medications: *(available at Acro only):*

☐Pomalyst®(pomalidomide) ☐Thalomid®(thalidomide) ☐Revlimid®(lenalidomide) ☐Dexamethasone
Please select one: ☐Adult Female – NOT of Reproductive Potential ☐Adult Female – Reproductive Potential ☐Adult Male
☐Female Child – NOT of Reproductive Potential ☐Female Child – Reproductive Potential ☐Male Child
Dose & Directions _____
Provider Authorization # _____Date:_____ Qty: _____

II. Supportive Medications:

Antiemetics: (Please specify dosage form, dose and directions) ☐Prochlorperazine ☐Ondansetron ☐Dolasetron ☐Emend® ☐Granisetron ☐Sancuso® ☐Akynzeo® ☐Other_____
Dose & Directions _____ Qty: _____ Refill:_____

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to ☐Acro ☐Commcare

Physician Signature:_____ ☐DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.
***Patient Signature:** (required for participation)_____ Date:_____ ☐ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program