



# VITAL CARE RX

*Tailored Therapy, Trusted Care*

## Oncology Enrollment Form

Phone: (877)229-1724 | Fax: (877)229-1725

### PATIENT INFORMATION

(Complete the following or **send patient demographic sheet.**)

**Please fax copy of patient's insurance card including both sides**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: M / F Height: \_\_\_\_\_ Wt: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Last 4 digits SS#: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber Name: \_\_\_\_\_

State Lic. #: \_\_\_\_\_ NPI: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Please Send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing

ICD-10 Code: \_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_ BSA: \_\_\_\_\_

Other Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Therapy: ☐ New ☐ Restart Prior Therapies: \_\_\_\_\_

### PRESCRIPTION INFORMATION

<u>Medication</u>	<u>Dose</u>	<u>Directions</u>	<u>Quantity</u>	<u>Refills</u>
<u>Medication</u>	<u>Dose</u>	<u>Directions</u>	<u>Quantity</u>	<u>Refills</u>

Deliver To: ☐ Home ☐ Physician \* If shipped to physician's office, physician accepts on behalf of patient for administration on office

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Brand Name Required? ☐ Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Revised July 2016