ONCOLOGY INFUSION

Lake Mary, FL toll free 855.733.3126 toll free fax 888.315.3270
krogerspecialtypharmacy.com

SPECIALTY PHARMACY

DATE: _____ NEEDS BY DATE: _____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Primary Diagnosis: _____ ICD-10: _____

Secondary Diagnosis: _____ ICD-10: _____

**To expedite Prior Auth services, PLEASE INCLUDE LAB/PATHOLOGY REPORT, PRIOR TREATMENT NOTES, AND CURRENT TREATMENT PLAN.

Drug Allergies: _____

Patient Weight: _____ kg. Patient Height: _____ Body Surface Area: _____

MED.	DOSE/STRENGTH	SIG (Please include cycle)	CYCLES	QUANTITY	REFILLS
❑ ABRAXANE®					
❑ ADCETRIS®					
❑ ALIMTA®					
❑ AVASTIN®					
❑ CARBOPLATIN®					
❑ ELOXATIN®					
❑ HERCEPTIN®					
❑ RITUXAN®					
		Total Dose = Target AUC x (GFR + 25) = mg			
❑ CISPLATIN®					
❑ DOCETAXEL®					
❑ ERBITUX®					
❑ GEMCITABINE®					
❑ KADCYLA®					
❑ PACLITAXEL®					
❑ TORISEL®					
❑ VELCADE®					
❑ ZOMETA					
❑ OTHER					
❑ OTHER					
❑ OTHER					

Pre-Meds: ❑ DEXAMETHASONE ____ IV X 1 DOSE ❑ DIPHENHYDRAMINE ____ IV X 1 DOSE ❑ RANITIDINE ____ IV X 1 DOSE
❑ ONDANSETRON ____ IV X 1 DOSE ❑ OTHER: _____ DOSE: _____ SIG: _____ REFILLS: _____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Dispense As Written Date

Prescriber's Signature (no stamps) Substitution Permitted Date