



SPECIALTY PHARMACY

ONCOLOGY INFUSION

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

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

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA #	NPI # License #
City, State, Zip		Address	
Main Phone	Alternate Phone	City, State, Zip	
Social Security #		Phone	Fax
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact Person	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

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: _____

DOSE/STRENGTH	SIG (Please include cycle)	QUANTITY	REFILLS
<input type="checkbox"/> ABRAXANE*			
<input type="checkbox"/> ADCETRIS*			
<input type="checkbox"/> ALIMTA*			
<input type="checkbox"/> AVASTIN*			
<input type="checkbox"/> CARBOPLATIN*			
<input type="checkbox"/> CISPLATIN*			
<input type="checkbox"/> DARZALEX*			
<input type="checkbox"/> DOCETAXEL*			
<input type="checkbox"/> ELOXATIN*			
<input type="checkbox"/> ERBITUX*			
<input type="checkbox"/> GEMCITABINE*			
<input type="checkbox"/> HERCEPTIN*			
<input type="checkbox"/> KADCYLA*			
<input type="checkbox"/> KYPROLIS*			
<input type="checkbox"/> OPDIVO*			
<input type="checkbox"/> PACLITAXEL*			
<input type="checkbox"/> RITUXAN*			
<input type="checkbox"/> TECENTRIQ*			
<input type="checkbox"/> TORISEL*			
<input type="checkbox"/> VELCADE*			
<input type="checkbox"/> VIDAZA*			
<input type="checkbox"/> YERVOY*			
<input type="checkbox"/> ZOMETA*			
<input type="checkbox"/> OTHER			

Pre-Meds:

<input type="checkbox"/> DEXAMETHASONE			
<input type="checkbox"/> DIPHENHYDRAMINE			
<input type="checkbox"/> RANITIDINE			
<input type="checkbox"/> ONDANSETRON			
<input type="checkbox"/> OTHER			

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)

Substitution Permitted

Date

Prescriber's Signature (no stamps)

Dispense As Written

Date

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