



SPECIALTY PHARMACY

ONCOLOGY

Irvine, CA toll free 855.313.9202 toll free fax 844.888.4157

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): _____
Drug Allergies: _____
Renal Dysfunction: ☐ Yes ☐ No Liver Dysfunction: ☐ Yes ☐ No Serum Creatinine: _____ HgB: _____ HCT: _____
☐ ALK positive testing for Xalkori Date: _____ Date: _____ Date: _____
☐ Confirmed BRAF V600 E Mutation for Tafenlar® or Mekinist ☐ Confirmed BRAF V600 K Mutation for Mekinist ☐ Previously on Zelboraf Weight: _____
ER: ☐ Positive ☐ Negative HER2: ☐ Positive ☐ Negative Metastatic: ☐ Yes ☐ No Height: _____
To expedite prior authorization services, please attach chemo regimen/schedule, last clinical notes and/or lab values/scans. BSA: _____

DOSE/STRENGTH	SIG (Please include cycle)	QUANTITY	REFILLS
<input type="checkbox"/> Afinitor®			
<input type="checkbox"/> Arimidex®			
<input type="checkbox"/> Aromasin®			
<input type="checkbox"/> Bosulif®			
<input type="checkbox"/> Erivedge®			
<input type="checkbox"/> Femara®			
<input type="checkbox"/> Gleevec®			
<input type="checkbox"/> Hycamtin®			
<input type="checkbox"/> Ibrance®			
<input type="checkbox"/> Inlyta®			
<input type="checkbox"/> Kisqali®			
<input type="checkbox"/> Mekinist®			
<input type="checkbox"/> Rydapt®			
<input type="checkbox"/> Sprycel®			
<input type="checkbox"/> Sutent®			
<input type="checkbox"/> Sylatron®			
<input type="checkbox"/> Tafenlar®			
<input type="checkbox"/> Tarceva®			
<input type="checkbox"/> Targretin®			
<input type="checkbox"/> Tasigna®			
<input type="checkbox"/> Temodar®			
<input type="checkbox"/> Tykerb®			
<input type="checkbox"/> Vidaza®			
<input type="checkbox"/> Votrient®			
<input type="checkbox"/> Xalkori®			
<input type="checkbox"/> Xeloda®			
<input type="checkbox"/> Xtandi®			
<input type="checkbox"/> Zolanza®			
<input type="checkbox"/> Zytiga®			
<input type="checkbox"/> Other			

Ninlaro, Pomalyst, Revlimid, Thalomid Please Use Celgene Form

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its 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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