



SPECIALTY PHARMACY

ONCOLOGY

New Orleans, LA toll free 888.355.4191 toll free fax 888.355.4192

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 Code(s): _____ **Please include Dx Code # and description

Prior Failed Meds: _____

PRESCRIPTION INFORMATION - DIRECTIONS			QUANTITY	REFILLS
<input type="checkbox"/> Afinitor [®]	_____	_____	_____	_____
<input type="checkbox"/> Avastin [®]	_____	_____	_____	_____
<input type="checkbox"/> Erivedge [®]	150mg tablet	_____	_____	_____
<input type="checkbox"/> Gleevec [®]	_____	_____	_____	_____
<input type="checkbox"/> Sprycel [®]	_____	_____	_____	_____
<input type="checkbox"/> Sutent [®]	_____	_____	_____	_____
<input type="checkbox"/> Tarceva [®]	<input type="checkbox"/> 25mg tablet	_____	_____	_____
	<input type="checkbox"/> 100mg tablet	_____	_____	_____
	<input type="checkbox"/> 150mg tablet	_____	_____	_____
<input type="checkbox"/> Targretin [®]	_____	_____	_____	_____
<input type="checkbox"/> Tasisna [®]	_____	_____	_____	_____
<input type="checkbox"/> Temodar [®]	_____	_____	_____	_____
<input type="checkbox"/> Xeloda [®]	_____	_____	_____	_____
<input type="checkbox"/> Zelboraf [®]	240mg tablet	_____	_____	_____
<input type="checkbox"/> Zytiga [®]	250mg tablet	_____	_____	_____
****FOR ALL BLOOD STIMULATING PRODUCTS PLEASE SEND A COPY OF THE MOST RECENT COMPLETE LABS DRAWN****				
<input type="checkbox"/> Aranesp [®]	_____	_____	_____	_____
<input type="checkbox"/> Neulasta [®]	_____	_____	_____	_____
<input type="checkbox"/> Neupogen [®]	_____	_____	_____	_____
<input type="checkbox"/> Procrit [®]	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____
<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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