



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	

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
<input type="checkbox"/> ABRAXANE [®]					
<input type="checkbox"/> ADCETRIS [®]					
<input type="checkbox"/> ALIMTA [®]					
<input type="checkbox"/> AVASTIN [®]					
<input type="checkbox"/> CARBOPLATIN [®]					
<input type="checkbox"/> ELOXATIN [®]					
<input type="checkbox"/> HERCEPTIN [®]					
<input type="checkbox"/> RITUXAN [®]					
Total Dose = Target AUC x (GFR + 25) = mg					
<input type="checkbox"/> CISPLATIN [®]					
<input type="checkbox"/> DOCETAXEL [®]					
<input type="checkbox"/> ERBITUX [®]					
<input type="checkbox"/> GEMCITABINE [®]					
<input type="checkbox"/> KADCYLA [®]					
<input type="checkbox"/> PACLITAXEL [®]					
<input type="checkbox"/> TORISEL [®]					
<input type="checkbox"/> VELCADE [®]					
<input type="checkbox"/> ZOMETA					
<input type="checkbox"/> OTHER					
<input type="checkbox"/> OTHER					
<input type="checkbox"/> 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 its 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

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10-14-2016 LMFL