Optum

Oncology Enrollment Form

Optum Specialty Phone: 877-445-6874 | Optum Specialty Fax: 866-306-5231

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here

This form is not a valid prescription in Arizona or Virginia

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name _____

Address _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

DOB _____ Last Four of SS# _____ Gender _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA/NPI _____

Group/Hospital _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Contact Person _____ Phone _____

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number _____

PA approved until (if known): _____

MEDICAL INFORMATION *(Section must be completed to process prescription)*

Diagnosis ICD10 _____

Description _____

Additional Information Therapy: ☐ New ☐ Reauthorization ☐ Restart

Description/Stage _____

Test Results: **Included:**

Please fax the following documentation:

- ☐ BMP or CMP _____ ☐ Yes ☐ No
- ☐ CBC or CBC w/ differential _____ ☐ Yes ☐ No
- ☐ CT/MRI/Other imaging studies _____ ☐ Yes ☐ No
- ☐ Chart/Surgical Notes _____ ☐ Yes ☐ No
- ☐ Genetic/diagnostic testing results _____ ☐ Yes ☐ No
- ☐ Other relevant results _____ ☐ Yes ☐ No

Weight _____ kg/lbs Height _____ cm/in BSA _____ m^2

Allergies _____

Prior Failed Therapies _____

History of drug resistance due to neutralizing immune antibody formations

Concomitant Medications _____

Additional Comments _____

Cumulative dose (applicable to anthracyclines) _____

Current Cycle # _____ Total # of Cycles _____

PRESCRIPTION INFORMATION

Medication

- ☐ Abiraterone
- ☐ Afinitor
- ☐ Alecensa®
- ☐ Augtyro
- ☐ Bexarotene capsules
- ☐ Bosulif®
- ☐ Bratovi
- ☐ Cabometyx®
- ☐ Capecitabine
- ☐ Cometriq
- ☐ Copiktra
- ☐ Cotellic™
- ☐ Cyclophosphamide
- ☐ Daurismo
- ☐ Deferasirox tablet for suspension
- ☐ Deferasirox film coated tablet
- ☐ Erivedge®
- ☐ Erleada™
- ☐ Erlotinib
- ☐ Etoposide
- ☐ Everolimus
- ☐ Farydak®
- ☐ Gefitinib
- ☐ Gleevec
- ☐ Gleostine®
- ☐ Hycamtin®
- ☐ Ibrance®
- ☐ Idhifa
- ☐ Imatinib
- ☐ Imbruvica
- ☐ Imfinzi
- ☐ Inlyta®
- ☐ Inqovi
- ☐ Inrebic®
- ☐ Iressa
- ☐ Jakafi®
- ☐ Jaypirca
- ☐ Keytruda®
- ☐ Khapzory
- ☐ Kisqali®
- ☐ Lapatinib
- ☐ Lenvima
- ☐ Leukeran®
- ☐ Lonsurf
- ☐ Lorbrena
- ☐ Lumakras
- ☐ Lunsumio
- ☐ Lynparza
- ☐ Mekinist®
- ☐ Mektovi
- ☐ Melphalan
- ☐ Mesnex
- ☐ Nerlynx
- ☐ Nexavar®
- ☐ Nilutamide
- ☐ Ninlaro®
- ☐ Nubeqa™
- ☐ Odomzo®
- ☐ Onureg
- ☐ Opdivo®
- ☐ Padcev
- ☐ Pazopanib
- ☐ Perjeta®
- ☐ Phesgo
- ☐ Piqray
- ☐ Promacta
- ☐ Purixan®
- ☐ Retevmo™
- ☐ Rituxan
- ☐ Rozlytrek®
- ☐ Rubraca
- ☐ Rydapt®
- ☐ Sorafenib
- ☐ Sprycel®
- ☐ Stivarga®
- ☐ Sunitinib
- ☐ Sutent®
- ☐ Tabloid®
- ☐ Tabrecta™
- ☐ Tafinlar®
- ☐ Tagrisso
- ☐ Talzenna®
- ☐ Tarceva
- ☐ Targretin®
- ☐ Targretin® gel
- ☐ Tasigna®
- ☐ Tecentriq
- ☐ Tecentriq Hybreza
- ☐ Temozolomide
- ☐ Tretinoin
- ☐ Tykerb®
- ☐ Venclexta
- ☐ Verzenio®
- ☐ Vidaza
- ☐ Vizimpro®
- ☐ Votrient®
- ☐ Xalkori®
- ☐ Xeloda
- ☐ Xtandi®
- ☐ Yervoy
- ☐ Yonsa®
- ☐ Zejula
- ☐ Zelboraf®
- ☐ Zolinza®
- ☐ Zydelig
- ☐ Zykadia™
- ☐ Zytiga
- ☐ _____
- ☐ Please see attached orders

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

☐ Infusable _____

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

* Prescriber Authorization: "I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network."

Ship to: ☐ Patient ☐ Office ☐ Other _____ Date _____ Date Needed _____

Dispense as Written

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

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