VERMONT

# ORAL ONCOLOGY/SELECT ADJUNCT

**Patient Enrollment/Prescription Form**

Complete form in its entirety and fax to number listed below

## 1 PATIENT INFORMATION

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Date of Birth | Sex M ☐ F ☐ | Medicaid ID # |
|---|---|---|
| | | |

Allergies: ☐ NKA or _____

| Street Address | City |
|---|---|
| | |

| State | County | Zip Code |
|---|---|---|
| | | |

| Home Phone | Cell Phone |
|---|---|
| | |

| Parent/Guardian | Day Telephone | Night Telephone |
|---|---|---|
| | | |

| Emergency Contact | Relationship | Telephone |
|---|---|---|
| | | |

## 2 PRESCRIBER INFORMATION

| Prescriber's Name | NPI Number | DEA Number |
|---|---|---|
| | | |

| Telephone Number | Fax Number | Hospital/Clinic Name |
|---|---|---|
| | | |

| Street Address | City |
|---|---|
| | |

| State | County | Zip Code |
|---|---|---|
| | | |

| Contact Person at Office | Prescriber Specialty |
|---|---|
| | |

briovaRx

GHS Goold Health Systems

**Fax Completed Form to:**

**Fax Number: 800-218-3221**

**Phone Number: 866-843-3604**

## 3 Department of Vermont Health Access PRESCRIPTION ORAL ONCOLOGY/SELECT ADJUNCT

Patient Diagnosis:

BSA(m2) _____ Patient height (cm) _____ Patient weight(kg)_____

☐ Maintenance Therapy # of Refills _____

☐ Cycle Specific Therapy NO REFILLS Cycle # _____

☐ Treatment / Dosage Change Reason : ☐ Toxicity ☐ Progression of Disease

☐ Change in BSA ☐ Other: _____

| MEDICATION | Normalized Dose (mg/m2, mg/kg, etc.) | Strength/ Frequency/ Route of Administration | QTY |
|---|---|---|---|
| ☐ GLEEVEC | | | |
| ☐ HEXALEN | | | |
| ☐ LUPRON DEPOT* | | | |
| ☐ MERCAPTOPURINE* | | | |
| ☐ MESNEX | | | |
| ☐ NEULASTA* | | | |
| ☐ NEUPOGEN* | | | |
| ☐ REVLIMID* | | | |
| Authorization # _____ | | New RX Required every 28 days | |
| ☐ SPRYCEL | | | |
| ☐ SUTENT | | | |
| ☐ TARCEVA | | | |
| ☐ TEMODAR | | | |
| ☐ XELODA | | | |
| **Other:** | | | |
| | | | |
| | | | |
| **Additional RX Instructions:** | | | |

**Prescriber's Signature:** _____ **Date:** _____

* Not required to use BriovaRx

Last Updated 12/2014