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

Ascend SpecialtyRX®

MedMetrics Health Partners an SXC company

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 Ascend

Last Updated 01/2012