



**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 <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> 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	



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/m ² , mg/kg, etc.)	Strength/ Frequency/ Route of Administration	QTY
<input type="checkbox"/> GLEEVEC			
<input type="checkbox"/> HEXALEN			
<input type="checkbox"/> LUPRON DEPOT*			
<input type="checkbox"/> MERCAPTOPYRINE*			
<input type="checkbox"/> MESNEX			
<input type="checkbox"/> NEULASTA*			
<input type="checkbox"/> NEUPOGEN*			
<input type="checkbox"/> REVLIMID*			
Authorization # _____	New RX Required every 28 days		
<input type="checkbox"/> SPRYCEL			
<input type="checkbox"/> SUTENT			
<input type="checkbox"/> TARCEVA			
<input type="checkbox"/> TEMODAR			
<input type="checkbox"/> XELODA			
Other:			
Additional RX Instructions:			
Prescriber's Signature: _____	Date: _____		

* Not required to use BriovaRx