



ONCOLOGY ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION	Patient: _____ Caregiver: _____
	DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Height: _____ in or cm (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ Cell Alternate Phone #: _____ Cell Email: _____
	Allergies: _____ Latex Allergy: Yes No
ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____	

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

MEDICAL ASSESSMENT	Renal Dysfunction: Yes No
	Current SCR: _____ or current GFR: _____ mt/min
	Liver Dysfunction: Yes No
	Abnormal Lab Value(s): _____
	H/H (Hemoglobin/Hematocrit): _____
	Confirmed Mutations: ALK BRAF V600E BRAF V600K CLL with 17p deletion PIK3CA Ph+ IDH1 IDH2 FLT3-ITD FLT3-TKD KIT exon11 KIT exon9 PDGFRA exon* _____ EGFR exon* _____ EGFR p. _____ Other: _____
*Attach genetic test result to the form	

COMPLETE THIS SECTION ONLY IF YOU WOULD LIKE USSC TO INITIATE A PRIOR AUTHORIZATION OR APPEAL ON YOUR BEHALF

PRIOR THERAPY:	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
_____	Disease Progression	_____
_____	Finished Therapy	_____
_____	Toxicity: _____	_____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

ORAL ONCOLYTICS

Afinitor _____ mg	Tarceva _____ mg	Targretin _____ mg	QTY: _____ Dosing & Sig: _____ Refill #: _____ **Authorization #: _____
Afinitor Disperz _____ mg	Odomzo 200mg cap	Tasigna _____ mg	
Cyclophosphamide 25mg cap	Piqray _____ mg	Temodar _____ mg	
Etoposide 50mg cap	Promacta _____ mg	Tretinoin 10mg cap	
Gleevec _____ mg	Purixan _____ mg/ml suspension	Votrient 200mg tab	
Kisqali _____ mg	Rydapt 25mg cap	Xeloda _____ mg	
Lomustine _____ mg	Sprycel _____ mg	Zolinza _____ mg	
Lonsulf _____ mg _____ mg	Tabloid 40mg tab	Zytiga _____ mg	
Mekinist _____ mg	Tafinlar _____ mg	Other: _____	
Ninlaro _____ mg			

INJECTABLE ONCOLYTICS

Avastin _____ mg/_____ ml	Octerotide _____ mcg/_____ ml	Sandostatin LAR Kit _____ mg	QTY: _____ Dosing & Sig: _____ Refill #: _____ **Authorization #: _____ *only one dosage form is available
Intron A _____ MU powder/vial/pen	SDV/MDV	Thyrogen (*1.1mg powder)	
Keytruda _____ mg powder, _____ mg/_____ ml vial	Pegasys _____ mg/_____ ml PFS/vial/ProClick	Zoladex Implant _____ mg	
Lupron depot _____ month _____ mg	Rituxan _____ mg/_____ ml vial		
	Rituxan Hycela _____ mg _____ units/_____ ml		

SUPPORT DRUGS

Aranesp _____ mcg/_____ ml vial/PFS	Lovenox _____ mg/_____ ml	Sancuso _____ mg/24hr	QTY: _____ Dosing & Sig: _____ Refill #: _____ **Authorization #: _____ *only one dosage form is available
Arixtra _____ mg/_____ ml	Mesna (*1g/10ml)	Udenyca (*6mg/0.6ml PFS)	
Caphosol _____ ml	Neulasta _____ mg/_____ ml	Valcyte 450mg tab, 50mg/ml vial	
Emend _____ mg	Neulasta Onpro (*6mg/0.6ml)	Xgeva (*120mg/1.7ml)	
Epogen _____ units/ml vial	Neupogen _____ mcg/_____ ml vial/PFS	Zarxio _____ mcg/_____ ml PFS	
Granix _____ mg/_____ ml vial/PFS	Neupogen: Vials Prefilled Syringes	Ziextenzo (*6mg/0.6ml PFS)	
Jadenu _____ mg tab	Nivestym _____ mg/_____ ml vial/PFS	Zofran _____ mg	
Jadenu Sprinkle _____ mg granules	Prevymis _____ mg tab, _____ mg/_____ ml vial	Zofran ODT _____ mg	
Leukine _____ mcg powder, _____ mcg/_____ ml soln	Procrit _____ units/ml vial	Zometa 4mg powder, _____ mg/_____ ml soln	
	Retacrit _____ units/ml vial	Other: _____	



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Patient: _____ DOB: _____

	INJECTION TRAINING:	OFFICE TO COORDINATE	WELLDYNE SPECIALTY TO COORDINATE
PRESCRIBER INFORMATION	Anticipated Start Date: _____		Prescriber Specialty: _____
	Ship to: Patient	Physician	Clinic
	Other: _____		
	Fax #: _____		Contact Name: _____
	Office Address: _____		City: _____ State: _____ Zip: _____
	The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.		
	The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.		
	I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.		
	Prescriber's Name: _____		Prescriber's Signature: _____ Date: _____
	Use substitution		Dispense as written

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