VERMONT

ORAL ONCOLOGY/SELECT ADJUNCT - Patient Enrollment/Order 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

iCORE PHARMACY SERVICES

MedMetrics HealthPartners

Fax Completed Form to:

Fax Number: 866-364-2673

Phone Number: 800-327-1392

3 Office 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
☐ ARIMIDEX*			
☐ AROMASIN*			
☐ CASODEX			
☐ FEMARA*			
☐ GLEEVEC			
☐ HEXALEN			
☐ LUPRON DEPOT*			
☐ MERCAPTOPURINE*			
☐ MESNEX			
☐ NEULASTA*			
☐ NEUPOGEN*			
☐ SPRYCEL			
☐ SUTENT			
☐ TARCEVA			
☐ TEMODAR			
☐ TRETINOIN			
☐ VESANOID			
☐ XELODA			
Other:			
Additional RX Instructions:			

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

* Not required to use ICORE

Last Updated 09/2009