ONCOLOGY AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PATIENT INFORMATION

Patient:______________________________ Caregiver: ______________________________

DOB:______________ ☐ Male or ☐ Female Weight:________ ☐ kgs or ☐ lbs (check one) Allergies:______________________

Address:______________________________ City:______________ State:__________ Zip:__________

Primary Phone #:______________________ ☐ Cell Alternate Phone #:______________________ ☐ Cell

Email:______________________________

CLINICAL INFORMATION

DIAGNOSIS DESCRIPTION: ______________________________ ICD-10 CODE:______________

☐ Adult Male ☐ Child Male ☐ Adult Female Not of Reproductive Potential ☐ Adult Female of Reproductive Potential

☐ Female Child Not of Reproductive Potential ☐ Female Child of Reproductive Potential

PRESCRIPTION INFORMATION

ORAL ONCOLYTICS

☐ Afinitor____mg ☐ Gleevec____mg ☐ Ninlaro____mg ☐ Sprycel____mg

☐ Sutent____mg ☐ Tasigna____mg ☐ Temodar____mg ☐ Xeloda____mg

☐ Zolinza____mg ☐ ________________mg

QTY: ______________________

DOSING & SIG: ______________________

Refill #: ______________________

**Authorization #: ______________________

SUPPORT DRUGS

☐ Aranesp: ○ Vials ○ Prefilled Syringes ☐ Arixtra ___mg/___ml ☐ Caphosol ___ml

☐ Emend ___mg ☐ Lovenox ___mg/___ml ☐ Neulasta___mg/___ml

☐ Neupogen: ○ Vials ○ Prefilled Syringes ☐ Procrit____units ☐ Sancuso___mg/24hr

☐ Zofran ___mg ☐ Zofran ODT ___mg

QTY: ______________________

DOSING & SIG: ______________________

Refill #: ______________________

PREVIOUS THERAPIES

COMPLETE THIS SECTION ONLY IF YOU WOULD LIKE PRAXIS Rx 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: ______________	______________

PRESCRIBER INFORMATION

Anticipated Start Date: ______________ Prescriber Specialty: ______________________

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:______________________

Prescriber: ______________________ NPI #: ______________ Phone #: ______________

Fax #: ______________Contact Name: ______________________

Office Address: ______________________ City: ______________ State: _____ Zip: _______

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: ______________________________ Date: ______________

☐ DAW, Brand Medically Necessary

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