ORAL ONCOLOGY

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Male/Female:	
Home Address:	City:	State:	Zip:
DOB:	Height:	Weight:	Allergies:
Phone (H):	Phone (C):	Phone (W):	
Email: _____ SSN #: _____			

**Complete and Attach Copies of card*

Insurance

Primary Insurance:	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	
Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity Date:

Diagnosis:

☐ 153-154 Metastatic Colorectal Cancer ☐ 205.1 Chronic Myeloid Leukemia ☐ 189 Renal Cell Carcinoma ☐ 202.1 Cutaneous T-Cell Lymphoma (Mycosis Fungoides)
☐ 202.2 Cutaneous T-Cell Lymphoma (Sezary's Disease) ☐ 152.9 Gastrointestinal Stromal Tumors ☐ 162.9 Pulmonary Malignancy
☐ 157.9 Adenocarcinoma of Pancreas ☐ 203 Multiple Myeloma ☐ 191.9 Glioblastoma ☐ 695.2 Erythema Nodosum (ENL)
☐ 155.0 Hepatocellular Carcinoma ☐ Other_____

- Has patient been treated previously for this condition? ___Yes ___No (If pt has been on Xeloda, please indicate dose and duration of therapy)
- Medications:_____
- Is patient currently on therapy? ___Yes ___No Medications:_____
- Will patient stop taking the above medication(s) before starting the new medication? ___Yes ___No If yes, what is the washout period?_____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____

Prescription

☐ XELODA 1250 mg/m2 po BID for 14 days followed by 7 days of rest (2 weeks on, 1 week off) ☐ Enroll in Moving Forward with Xeloda Program

(Xeloda is available in 500 mg and 150 mg tablets. A combination of both strengths will be dispensed based on patient's total daily dose unless otherwise indicated).

Please indicate number of tablets to be taken at each dose:

Dosage: (_____of 500mg & _____of 150mg tabs) every AM & (_____of 500mg & _____of 150mg tabs) every PM for _____ days followed by _____ days of rest.

Dose adjustment based on: creatinine clearance or combination therapy with Docetaxel and/or toxicity NCIC grads:_____ Qty:_____ Refills:_____

☐ TEMODAR ☐ 5mg cap ☐ 20 mg cap ☐ 100mg cap ☐ 140mg cap ☐ 180mg cap ☐ 250mg cap

(Will dispense combination of different strengths based on pt's total daily dose if it is not indicated, quantity will be calculated for each strength based on sig/cycle)

Total daily dose based on BSA: _____ mg po daily for_____days on and_____days off, repeat cycle every_____days for_____cycles

Alt. Dosage: _____ Qty: ____ Refills: ____ Labs to be monitored by MD and dose to be modified based on ANC and platelet levels.

☐ GLEEVEC ☐ 100mg tab ☐ 400mg tab (will dispense combination of 100 mg and 400 mg tab based on pt's dose) Dosage _____ Qty:_____ Refills: _____

☐ SPRYCEL ☐ 20mg tab ☐ 50mg tab ☐ 70mg tab Dosage:_____ Qty:_____ Refills: _____

☐ SUTENT ☐ 12.5mg cap ☐ 25mg cap ☐ 50mg cap ☐ 50mg po daily for 4 wks on and 2 wks off. Alt. Dosage: _____ Qty:_____ Refills: _____

☐ THALOMID ☐ 50mg cap ☐ 100mg cap ☐ 150mg cap ☐ 200mg cap (Please fax the Thalomid prescription for the maximum of 28 days supply with no refill which includes authorization #. Prescription and authorization # is only valid for 7 days)

☐ ANTIEMETICS ☐ Chemo-induced N/V ☐ Radiation-induced N/V ☐ Compazine ☐ Emend ☐ Zofran ☐ Sancuso Transdermal Patch ☐ Other: _____
Dosage: _____ Qty:_____ Refills: _____

☐ NEUPOGEN ☐ Daily x_____days ☐ Evey week ☐ BIW ☐ TIW ☐ 300mcg SQ ☐ 480mcg SQ ☐ Other:_____ Qty:_____ Refills: _____

☐ NEULASTA Dosage: _____ Qty:_____ Refills: _____

☐ PROCRIT ☐ EPOGEN ☐ 40,000 units SQ QWK Dosage:_____ Qty:_____ Refills: _____

☐ ARANESP Dosage: _____ Qty:_____ Refills: _____

☐ NEUMEGA 5mg vial Dosage: _____ Qty:_____ Refills: _____

☐ OTHER _____ Qty:_____ Refills: _____

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Physician; ☐ Other_____ *All the supplies including syringes and needles will be dispensed if requested.*

Physician Signature: _____ ☐ DAW (Dispense as Written) Date:_____

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

Patient Signature:_____ Date:_____