LINDEN RETAIL SPECIALTY PHARMACY

ONCOLOGY ORAL MEDICATIONS HEMATOLOGIC MALIGNANCIES ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976

Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender ◯ Male ◯ Female

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to ☐ Patient ☐ Office ☐ Other _____

Diagnosis (ICD-10):

☐ C61 Prostate Cancer ☐ Other Code _____ Description _____

Patient Clinical Information

Allergies _____ Weight _____ lb/kg Height _____ in/cm BSA: _____ m2

5 PRESCRIPTION INFORMATION

MEDICATIONS:

☐ Revlimid REMS™ Program Physician Auth Number: _____ Date: _____

☐ Pomalyst REMS™ Program Physician Auth Number: _____ Date: _____

☐ Thalomid REMS™ Program Physician Auth Number: _____ Date: _____

Diagnosis:

☐ MDS D46.9

☐ MM C90.00

☐ MCL C83.10

PREGNANCY CATEGORY:

☐ Adult Female – Reproductive Potential ☐ Adult Female – NOT of Reproductive Potential ☐ Adult Male

☐ Female Child – Reproductive Potential ☐ Female Child – NOT of Reproductive Potential ☐ Adult Male

MEDICATIONS:

☐ Bosulif® (bosutinib)
☐ Farydak® (panobinostat)
☐ Gleevec® (imatinib mesylate)
☐ Idhifa® (enasidenib)
☐ Jakafi® (ruxolitinib)
☐ Lumoxiti™ (moxetumomab)
☐ Ninlaro® (ixazomib)
☐ Pomalyst® (pomalidomide)
☐ Poteligeo® (moxetumomab)
☐ Purixan® (mercaptopurine)
☐ Revlimid® (lenalidomide)
☐ Rydapt® (midostaurin)
☐ Sprycel® (dasatinib)
☐ Targretin® Capsules (bexarotene)
☐ Tasigna® (nilotinib)
☐ Thalomid® (thalidomide)
☐ Zolinza® (vorinostat)
☐ Zydelig® (idelalisib)
☐ Other: _____

PRESCRIPTIONS	DRUG NAMES/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
☐ RX 1	☐ Other _____	☐ _____	Quantity: _____ Refills: _____
☐ RX 2	☐ Other _____	☐ _____	Quantity: _____ Refills: _____
☐ RX 3	☐ Dexamethasone	☐ _____	Quantity: _____ Refills: _____

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

6 PYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____