ONCOLOGY **ENROLLMENT FORM**

PLEASE FAX: FOURTH STREET - 302-502-3885 • MARKET STREET - 302-513-9396

GREENHILL PLUS+ Specialty Pharmacy Solution

Connection • Care • Community

Greenhill Pharmacy | 2511 W 4th St, Wilmington, DE 19805

Patient Information

Patient Name _____

Address _____

Apt/Suite _____ City _____

State _____ Zip _____

Home Phone _____ Alternate Phone _____

DOB _____ SSN _____ Gender ○ M ○ F

Weight _____ kg/lbs Height _____ cm/in

Known Allergies _____

Alternate Caregiver Name _____ Phone _____

Prescriber Information

Provider Name(s) _____ NPI _____

Practice Name _____

Address _____

City _____

State _____ Zip _____

Tax ID# _____

Phone _____ Fax _____

Key Contact _____ Phone _____

Clinical Information (Section must be completed to process prescription)

To expedite prior authorization services, please FAX current and past Chemo regimen(s)/schedule, last clinical notes and/or lab values/scans

Diagnosis:

ICD-10: (required for Medicare B billing)

BSA _____ m2

Renal Dysfunction: ○Yes ○No

Current SCr _____ or current GFR _____ ml/min

Liver Dysfunction: ○ Yes ○ No

Abnormal Lab Value(s):

H/H (Hemoglobin/Hematocrit):

Confirmed Mutations: ○ EGFR ○ ALK ○ BRAF V600E ○ BRAF V600K

CLL with 17p deletion ○ Other:

Prescription Information

Solid Tumors

○Afinitor® (everolimus) ○Afinitor® Disperz (everolimus) ○Arimidex® (anastrozole) ○Erivedge® (vismodegib) ○Femara® (letrozole) ○Hycamtin® (topotecan)

○Inlyta® (axitinib) ○Iressa® (gefitinib) ○Mekinist® (trametinib) ○Nexavar® (sorafenib) ○Nolvadex® (tamoxifen) ○Rubraca™ (rucaparib)

○Stivarga® (regorafenib) ○Sutent® (sunitinib) ○Sylatron® (peginterferon alfa-2b) ○Tafinlar® (dabrafenib) ○Tagrisso™ (osimertinib) ○Tarceva® (erlotinib)

○Temodar® (temozolomide) ○Tykerb® (lapatinib) ○Votrient® (pazopanib) ○Xalkori® (crizotinib) ○Xeloda® (capecitabine) ○Xtandi® (enzalutamide)

○Zykadia™ (ceritinib) ○Zolinza® (vorinostat) ○_____

Liquid Tumors

○Bosulif® (bosutinib) ○Exjade® (deferasirox) ○Farydak® (panobinostat) ○Gleevec® (imatinib) ○Jadenu™ (deferasirox) ○Jakafi® (ruxolitinib)

○Sprycel® (dasatinib) ○Tasigna® (nilotinib) ○Zydelig™ (idelalisib) ○_____

Direction **Quantity** **Refills**

_____

_____

_____

○Pomalyst® (pomalidomide) ○Thalomid® (thalidomide) ○Revlimid® (lenalidomide) ○Dexamethasone® (dexamethasone)

Please check one: ○Adult Female - NOT of reproductive potential ○Adult Female - of reproductive potential ○Male Child

○Female Child - NOT of reproductive potential ○Female Child - of reproductive potential ○Adult Male

Direction **Quantity** **Refills**

Supportive Medication

○Aranesp® (darbepoetin alfa) ○Arixtra® (fondaparinux) ○Emend® (aprepitant) ○Granix® (tbo-filgrastim) ○Lovenox® (enoxaparin) ○Neulasta® (pegfilgrastim)

○Neupogen® (filgrastim) ○Nplate® (romiplostim) ○Procrit® (epoetin alfa) ○Promacta® (eltrombopag) ○Sancuso® (granisetron) ○Xgeva® (denosumab)

○Zarxio® (filgrastim-sndz) ○Zofran® (ondansetron) ○_____

Direction **Quantity** **Refills**

Provider Authorization # _____ **Date** _____

Drugs	Direction	Quantity	Refills
○**Kisqali®** (ribociclib)	○600 mg orally once daily for 21 days, then 7 days off Inject 400 mg subcut every 4 weeks		
○**w/ Letrozole**	○2.5 mg orally once daily (or another aromatase inhibitor) throughout the 28-day cycle.		
○**Imbruvica™** (ibrutinib)	○_____ Waldenström's macroglobulinemia is 420mg (3 capsules) - Mantle Cell Lymphoma is 560mg (4 capsules) Chronic Lymphocytic Leukemia is 420mg (3 capsules)		
○**Lonsurf®** (tipiracil/trifluridine)	○15 mg/6.14 mg ○20 mg/8.19 mg Take _____ mg (35mg/m2 based on trifluridine component) twice daily within 1 hour of completion of morning and evening meals on days 1 through 5 and days 8 through 12 of each 28-day cycle. (round dose to nearest 5mg, max of 80mg/dose)		
○**Cotellic™** (cobimetinib)	○Three tablets (60mg) for 21-days on and 7-days off, then repeat	○240 tablets	
○**Zelboraf®** (vemurafenib)	○Four tablets (960mg) every 12 hours	○240 tablets	
○**Allopurinol** (venetoclax)			

Drugs	Direction	Quantity	Refills
○**Zytiga®** (abiraterone)	○250 mg 4 QD		
○**w/ Prednisone**	○5 mg BID w/ food		
○**Ibrance®** (palbociclib)	○_____ mg QD w/ food for 21 days, then 7 days off	□21 caps	
○**w/ Letrozole**	○1 tablet (2.5 mg) QD	□28 tablets	
○**Ninlaro** (ixazomib)	○One ____ mg capsule once weekly on days 1, 8, and 15 of a 28-day cycle, 1 hour before or 2 hours after food	□3 capsules	
○**Revlimid**	○One ____ mg capsule for 21 days, then 7-days off, then repeat cycle Prov. Auth. # _____	□21 capsules	
○**Dexamethasone**	○40mg (10 tablets) once weekly on days 1,8,15, and 22 of a 28-day cycle	□40 tablets	
○**Venclexta™** ○10mg ○Wallet ○Unit dose ○50mg ○Wallet ○Unit dose ○100mg ○120 Bottle ○Unit dose	○Starter Pack Ramp-up dosing: Week 1: 20mg po QD; Week 2: 50mg po QD; Week 3: 100mg po QD; Week 4: 200mg po QD _____ ○Maintenance: 400mg po qd after completion of ramp-up dosing _____		

Ship to: ○ ***Patient*** ○ ***Office*** ○ ***Other*** _____ ***Date*** _____ ***Needs by Date*** _____

Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

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

PRODUCT SUBSTITUTION PERMITTED DISPENSE AS WRITTEN

Supervising Physician / Supervising Physician Signature: _____

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NEW REFERRAL CHECKLIST
PLEASE USE THIS CHECKLIST FOR ONCOLOGY PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days. ***Please forward to us any updates you receive from the insurance company regarding approvals or denials.***

REQUIRED INFORMATION:

- ☐ Patient Name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc.)
- ☐ Medication list and allergies
- ☐ Insurance information with prescription insurance. Please include a copy of card.
  If only medical insurance card is provided, please include local pharmacy information.
- ☐ MD Name/NPI/Office Contact/Phone Number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Diagnosis Code
- ☐ Previous therapies listed
- ☐ Concurrent medications for same diagnosis
- ☐ Quantity, frequency and cycle of medication

GREENHILL PHARMACY (MARKET STREET)
824 N Market St., Wilmington, DE 19801
Physician Line: 302-516-7480 | Patient Line: 302-516-7507
Fax: 302-513-9396

GREENHILL PHARMACY (FOURTH STREET)
2511 W. 4th St. Suite F, Wilmington, DE 19805
Physician Line: 302-691-7833 | Patient Line: 302-660-8847
Fax: 302-502-3885

www.thegreenhillpharmacy.com