InfuCare Rx®

Oncology Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

✂ Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ C80.1 Malignant neoplasm, unspecified
☐ Other: _____
Prior Medication Failed: _____
Length of Treatment: _____
Reason for Discontinuation: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: _____
For all blood stimulating products please send a copy of most recent labs drawn.

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills

ADDITIONAL COMMENTS

Prescriber Signature: _____ **Date:** _____

✂

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