Oncology

Please fax to
855.291.7860

EntrustRx
Specialty Pharmacy With A Personal Touch
wholly owned subsidiary of fred's inc.
™ 4284 New Getwell Road
Memphis, TN 38118
p 901.367.9484
tf 855.394.2930

PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Home Address ______________________ City ______________ State _______ Zip __________

Home Phone ______________ Work/Mobile Phone ______________ E-mail ______________________

Social Security # ______________________ Date of Birth ______________ Gender: ❑ Male ❑ Female

Primary Caregiver ______________________ Relation ______________ Phone ______________

Emergency Contact ______________________ Relation ______________ Phone ______________

INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

1. Primary Insurance ______________ ID # ______________ Group # ________ Phone______________

   Insured's Name ______________ Insured's Employer ______________ Relationship______________

2. Secondary Insurance ______________ ID # ______________ Group # ________ Phone______________

   Insured's Name ______________ Insured's Employer ______________ Relationship______________

CLINICAL INFORMATION

********** ***Please send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing*** **********

ICD-10 Code __________Primary Diagnosis ______________________Current Weight ______kg/lb Height ________inches/cm BSA________m2

Allergies: ❑ Yes ❑ No If yes, please list ____

Therapy: ❑ New ❑ Restart Prior Therapies:

MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

SUPPORTIVE MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

Deliver To: ❑ Home ❑ Physician* **If shipped to physcian's office, physician accepts on behalf of patient for administration in office.*

Anaphylaxis Kit Needed: ❑ Yes ❑ No *If yes, please provide patient with a prescription for an EpiPen which he/she may pick up at their pharmacy of choice.*

PHYSICIAN INFORMATION

Physician Name ______________________ Contact Name ______________________

NPI #______________ DEA # ______________ Lic # ______________ Tax ID# ______________

Phone/Fax ______________________ E-mail ______________________

Address ______________________ City ______________ State ________ Zip __________

I authorize to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature ______________________ ______________________ **Date**__________

Dispense as Written Substitution Permissible

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