

Summary of SWON Rx Oncology Services

Toll Free Ph: 877-977-9118
Toll Free Fx: 877-305-2089

"NEW"

Web-based Rx Portal

Real-time Rx status specific to your patients; UPS shipment tracking details; obtain personal access via Shawna Brown at 1-877-977-9118 ext 10854 or email at sbrown@diplomatpharmacy.com.

Insurance Prior Authorization/Co-Payment Assistance for Medicare Part B & D

Dedicated PA & FUNDING DEPARTMENT manages these increasing challenges; qualifying patients can receive up to \$10,000 in co-payment support;

Special Compliance Packaging

Special Compliance Packaging to increase adherence and simplify complex Rx regimen is available for selected drugs;

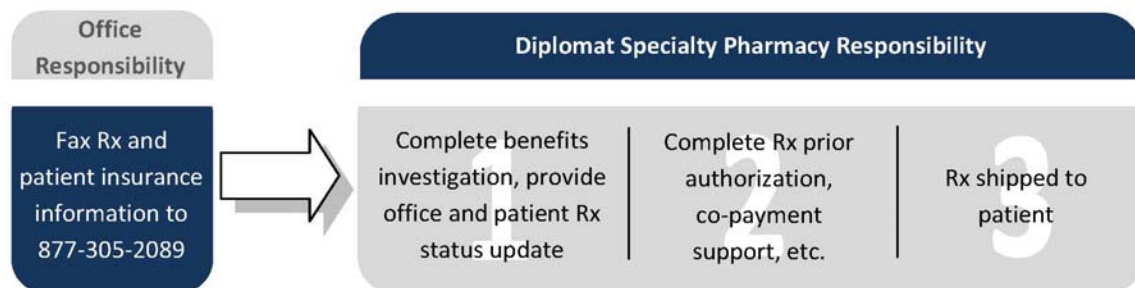
Compounded Dexamethasone (DEX) into a Single Capsule

Single capsule 20mg or 40mg Dexamethasone significantly reduces pill burden and fits into compliance packaging upon request; excellent with combination therapy of Revlimid plus DEX for Multiple Myeloma;

National Coverage & Major Plan Access

National distribution sites;

EASY Process



Shawna Brown

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AFINITOR[®], FEMARA[®], GLEEVEC[®], HYCAMTIN[®], NEXAVAR[®], REVLIMID[®], SPRYCEL[®], SUTENT[®], TAMOXIFEN[®], TARCEVA[®], TASIGNA[®], TEMODAR[®], THALOMID[®], TYKERB[®], VOTRIENT[®], XELODA[®]



Oncology Enrollment Form Patient Information



Toll Free Phone: 877.977.9118

Toll Free Fax: 877.305.2089

Ship To: Patient Physician/Clinic Date Shipment Needed: _____ **Rx:** New Refill _____

Date: _____ Patient SS#: _____ Adult Male Child Male
 Adult Female - Non Childbearing Adult Female - Childbearing Female Child - Non Childbearing Female Child - Childbearing

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City/County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____

Allergies: _____ Diagnosis Description: _____ ICD9 Code: _____

Insurance Information (fill out entirely OR fax copy of patient's insurance card - both sides and patient face sheet)

Primary Insurance: _____ Secondary Insurance: _____

Insured: _____ Insured: _____

Phone: _____ Phone: _____

Policy#: _____ Group#: _____ Policy#: _____ Group#: _____

BIN #: _____ PCN#: _____ BIN #: _____ PCN#: _____

If available, local pharmacy #: _____

PRESCRIPTION

ORAL ONCOLYTICS (please circle)				DOSING & SIG:
Afinitor	Arimidex	Femara	Gleevec	
Hycamtin	Nexavar	Revlimid**	Sprycel	
Sutent	Tamoxifen	Tarceva	Tasigna	
Temodar	Thalomid**	Tykerb	Xeloda	
Votrient				
Other: _____				

SUPPORT DRUGS (please circle)				DOSING & SIG:
Aranesp	Arixtra	Caphosol	Emend	
Lovenox	Neulasta	Neupogen	Nplate*	
Procrit	Promacta	Sancuso	Zofran	
Other: _____				
Other: _____				

Physician's name: (please print) _____ Contact Person: _____

Phone Number: _____ Fax Number: _____

Office Address: _____ City: _____ State: _____ Zip: _____

License# _____ NPI# _____ UPIN# _____ MEDICAID Provider# _____

Physician's signature: _____ M.D. DEA# _____

I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.