Oncology
Patient Services Enrolment Form

Tel: 1-888-398-0028 | Email : accesslink@bioscript.ca

Please fax completed form to: 1-855-278-5182 (Fax)

Patient Information

Name: _____ **DOB:** (DD/MM/YYYY) ____/____/_____
Gender: ☐ Male ☐ Female ☐ Other: **Language:** ☐ EN ☐ FR ☐ OTH:
Allergies: _____
Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____
Email: _____ **Home#:** _____ **Mobile#:** _____
Preferred Contact Person: ☐ Patient ☐ Caregiver **Caregiver Relationship to Patient:** _____
Caregiver Name: _____
Caregiver Email: _____ **Caregiver Phone#:** _____
Preferred Contact Via: ☐ Call ☐ Email **Authorization to leave voicemail:** ☐ Y ☐ N
Best time to reach Patient/Caregiver: ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime
☐ **Patient consents to BioScript AccessLink using this form's information for PSP enrollment and contact**
☐ **Verbal Consent Received by:** _____ **Date of Consent:** (DD/MM/YYYY) ____/____/_____

Insurance Information

Public Drug Coverage

Health Card #: _____
Coverage Type: _____ **Provincial Special Authorization Approval:** ☐ Y ☐ N

Private Drug Coverage

Private Drug Plan: ☐ Y ☐ N **%Covered:** _____ **Private Insurance Provider:** _____
Prior Authorization Submitted? ☐ Y ☐ N **Date Submitted:** (DD/MM/YYYY) ___/____/_____
Policy Holder Name: _____ **Policy Holder DOB:** (DD/MM/YYYY) ___/____/_____
Policy/Member ID: _____ **Relationship to Patient:** _____
Carrier #: _____ **Group/Contract #:** _____
Private Insurance Card(s) scan attached (optional): ☐ Y ☐ N
Plan Maximum: _____
Notes: _____

Medical Information

Clinic Nurse / DAN: _____ **Pharmacist:** _____
Phone: _____ **Phone:** _____
Fax: _____ **Fax:** _____
Email: _____ **Email:** _____

Medical Diagnosis:

☐ Chronic Myeloid Leukemia (CML) ☐ Acute Lymphoblastic Leukemia (ALL)
☐ Gastrointestinal Stromal Tumor (GIST) ☐ Chronic Myelogenous Leukemia (CML)
☐ Philadelphia Chromosome Acute Lymphoblastic Leukemia (Ph+ALL)
☐ Prostate – Metastatic (castration-resistant) ☐ Other: _____

BPMH / Medication List attached: ☐ Y ☐ N

Notes / Other considerations:

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Patient Name: _____ **DOB(DD/MM/YYYY):**_____

Prescription

Imatinib (Gleevec) Oral Tablet ☐ 100mg ☐ 400mg

Dasatinib (Sprycel) Oral Tablet ☐ 20mg ☐ 50mg ☐ 70mg ☐ 80mg ☐ 100mg ☐ 140mg

Abiraterone (Zytiga) Oral Tablet ☐ 250mg ☐ Blood Pressure Monitor

SIG: **Quantity:** _____ **Refills:** _____

Therapy Start Date (if available): (DD/MM/YYYY) _____/_____/_____

Prescriber Information

Physician Signature: **License #:** **Date:** (DD/MM/YYYY)

_____ _____ _____/_____/_____

MD Name: (printed) _____

Physician Address: _____

☐ PLEASE INDICATE IF THE PRESCRIPTION WILL BE SENT SEPARATELY