

Patient Information				Prescriber Information	
Patient Name:		DOB:		Prescriber's Name:	
Address:				NPI#:	
City:	State:	Zip:		DEA#:	License#:
Phone:		Alternate Phone:		SSN:	
Height:	Weight:	Allergies:		Phone:	Fax:
Emergency Contact:		Phone:		Contact Person:	
Is the patient pregnant, planning a pregnancy or nursing:				Yes	No
				Does the patient need interpreter services:	
				Yes	No

Documentation (Required)		
Insurance Card (front and back)	Current Medications	History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

Other: _____

Client Considerations

Prescriber's Name: R11.0 Nausea
 R11.11 Vomiting without Nausea
 R11.2 Nausea with vomiting unspecified
 Other (please specify): _____

Medication	Dose	Directions for Use	Qty	Refills
SANCUSO® (Granisteron Transdermal Patch)	34.3mg	Apply single transdermal patch to the upper outer arm minimally 24 hours before chemotherapy. Remove patch minimally 24 hours after completion of chemotherapy.		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature

Date