Sancuso® (Granisetron Transdermal System)

Enrollment Form

Please fax completed form & all required documents to (629) 278-7080
Toll-Free Number: 1-888-880-9480 **Email:** hubservices@healix.net

Sancuso® (Granisetron Transdermal System)

patient Rx solutions

PATIENT DEMOGRAPHICS

Patient Name: DOB: Phone:

Address: City/ST/Zip:

Allergies: ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal Sex: ☐ Male ☐ Female ☐ Unknown

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Nausea, ICD10 R11.0
☐ Vomiting, unspecified, ICD10 R11.10
☐ Nausea and vomiting, unspecified, ICD10 R11.2
☐ Encounter for antineoplastic chemotherapy, ICD10 Z51.11
☐ Adverse effect of antineoplastic and immunosuppressive drugs), ICD10 T45.1X5A
☐ Adverse effect of antineoplastic and immunosuppressive drugs), ICD10 T45.1X5D
☐ Adverse effect of antineoplastic and immunosuppressive drugs), ICD10 T45.1X5S
☐ Other: _____ ICD10:

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS/DURATION	QTY
Sancuso® (Granisetron Transdermal System)	1 transdermal system delivering granisetron 3.1 mg / 24 hours	Apply a single transdermal system to the upper outer arm 24-48 hours before chemotherapy. A single transdermal system can be worn for up to 7 days. Chemotherapy regimen: _____ Frequency:_____ # of cycles: _____	# of Patches: _____ # of Patches: _____

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment: _____

PRESCRIBER INFORMATION

Prescriber's Signature: _____ Date:

Prescriber's Name: Provider NPI: Specialty:

Address: City/ST/Zip: _____

Contact Person: Phone #: Fax #:

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ Sancuso® (granisetron) will be administered for:
- ☐ Prevention of chemotherapy-induced nausea and vomiting
- ☐ Treatment of breakthrough nausea and/or vomiting due to chemotherapy

☐ The patient will be receiving moderately and/or highly emetogenic chemotherapy for up to five consecutive days.
Please specify chemotherapy regimen: _____

☐ The patient is at risk for chemotherapy-induced nausea or vomiting.
Please specify:
- ☐ Young age (<55 years)
- ☐ Female sex
- ☐ Previous history of chemotherapy induced nausea or vomiting
- ☐ Little or no previous alcohol use
- ☐ History of motion sickness or morning sickness during pregnancy
- ☐ High anxiety
- ☐ Other:

☐ The patient is unable to swallow or digest tablets/capsules.

PRIOR FAILED THERAPIES FOR NAUSEA/VOMITING

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

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