

For assistance, contact your pharmacy representative: \_\_\_\_\_ Phone: \_\_\_\_\_ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is not a prescription. Please submit prescriptions electronically or via fax along with this form.



### Clinical Data by Cancer Type

Central Pharmacy: \_\_\_\_\_  
 Retail/Community Pharmacy Fax: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

List of medications ordered (this form is not a prescription): \_\_\_\_\_

Date Needed By: \_\_\_\_\_

#### PATIENT INFORMATION

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_

Insurance provider (Please include copy of front and back of card): \_\_\_\_\_

ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  Patient is eligible for Medicare

Name of Insured: \_\_\_\_\_ Employer: \_\_\_\_\_

#### CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

ICD-10 code: \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

Patient is new to therapy  Patient is currently on therapy Start date: \_\_\_\_\_

Treatment history (or attach clinical notes reflecting history):

Please indicate the documents(s) attached:

Failed therapies  Recent laboratory results  Recent pathology report  Recent office notes  Copy of front and back of insurance card

Weight: \_\_\_\_\_ lb  kg Date: \_\_\_\_\_ Height: \_\_\_\_\_ in  cm Date: \_\_\_\_\_ BSA: \_\_\_\_\_ m<sup>2</sup>

Allergies: \_\_\_\_\_

#### CANCER TYPES

##### Acute Lymphoblastic Leukemia (ALL):

Philadelphia chromosome status  Positive  Negative  N/A

##### Acute Myeloid Leukemia (AML):

FLT3 mutation  Positive  Negative  N/A

IDH2 mutation  Positive  Negative  N/A

##### Breast & Ovarian Cancer:

BRCA mutation  Positive  Negative  N/A

PIK3CA mutation  Positive  Negative  N/A

Estrogen Receptor status  Positive  Negative  N/A

HER2 status  Positive  Negative  N/A

Progesterone Receptor status  Positive  Negative  N/A

Is patient postmenopausal?  Yes  No

##### Chronic Lymphocytic Leukemia (CLL):

17p deletion  Positive  Negative  N/A

##### Chronic Myeloid Leukemia (CML):

Philadelphia chromosome status  Positive  Negative  N/A

##### Colorectal Cancer:

KRAS Wild Type  Positive  Negative  N/A

##### Lung Cancer:

ALK gene rearrangement  Positive  Negative  N/A

BRAF mutation, V600E  Positive  Negative  N/A

EGFR, exon 19 deletion  Positive  Negative  N/A

EGFR, exon 21 substitution  Positive  Negative  N/A

EGFR, T790M mutation  Positive  Negative  N/A

ROS1 gene alteration  Positive  Negative  N/A

##### Melanoma:

BRAF mutation, V600E  Positive  Negative  N/A

BRAF mutation, V600K  Positive  Negative  N/A

Surgery date: \_\_\_\_\_

##### Myelodysplastic Syndrome (MDS) / Myeloproliferative diseases or Neoplasms:

Deletion 5q  Positive  Negative  N/A

JAK2 status  Positive  Negative  N/A

PDGF Receptor Gene status  Positive  Negative  N/A

##### Other:

D816V c-Kit  Positive  Negative  N/A

FIP1L1-PDGF receptor alpha fusion kinase  Positive  Negative  N/A

Kit (CD117)  Positive  Negative  N/A

NTRK Gene Fusion  Positive  Negative  N/A

#### PRESCRIBER INFORMATION

Prescriber's name: \_\_\_\_\_ Practice/facility: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Office contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email (optional): \_\_\_\_\_ Best time to call: \_\_\_\_\_ Preferred method of contact:  Email  Phone  Fax

I certify that the above information is accurate to the best of my knowledge.

Prescriber or Authorized Healthcare Provider Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_

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