

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

Pharmacy: _____
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: _____ m²
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:

BRAF mutation, V600E Positive Negative N/A

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

Lung Cancer:

EGFR, exon 21 substitution Positive Negative N/A

EGFR, T790M mutation Positive Negative N/A

MET exon 14 skipping Positive Negative N/A

RET fusion 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

RET fusion Positive Negative N/A

RET mutant 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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