

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 intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital (may not be faxed by patient).



Other Cancers

Prescription/Pharmacy Intake Form

Pharmacy: _____ Pharmacy Fax: _____ Pharmacy Phone: _____ Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

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

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

Patient is new to therapy Patient is currently on therapy Start date: _____ ICD-10 code: _____ ICD-10 description: _____ Weight: _____ lb kg Date: _____ Height: _____ in cm Date: _____ BSA: _____ m^2 Allergies: _____

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

Colorectal Cancer:

BRAF mutation, V600E Positive Negative

KRAS Wild Type Positive Negative

Other:

Kit (CD117) Positive Negative

RET fusion Positive Negative

NTRK Gene Fusion Positive Negative

RET mutant Positive Negative

Table with 5 columns: Medication, Dose/Directions/Frequency, Qty, Refills. Rows include various cancer medications like Afinitor, Erleada, etc.

* Available at select health system pharmacy locations only.

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____ Address: _____ City: _____ State: _____ Zip code: _____ Office contact: _____ Phone: _____ Fax: _____ Email: _____ Best time to call: _____ Preferred method of contact: Email Phone Fax State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.