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 MD office or hospital **(may not be faxed by patient)**.

Blood 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

Test	Result	Test	Result
17p Deletion	☐Positive ☐Negative	**IDH2 mutation**	☐Positive ☐Negative
D816V c-Kit	☐Positive ☐Negative	**JAK2 Status**	☐Positive ☐Negative
Deletion 5q	☐Positive ☐Negative	**PDGFR gene re-arrangements**	☐Positive ☐Negative
FIP1L1-PDGFRα fusion kinase	☐Positive ☐Negative	**Philadelphia Chromosome**	☐Positive ☐Negative
FLT3 mutation	☐Positive ☐Negative		

Medication	Dose/Directions/Frequency	Quantity	Refills
☐Bosulif ☐Calquence* ☐Daurismo† ☐Farydak ☐Gleevec ☐Idhifa ☐Inqovi ☐Inrebic ☐Intron A ☐Jakafi ☐Matulane ☐Ninlaro ☐Onureg ☐Rydapt ☐Sprycel ☐Targretin ☐Tasigna ☐Zolinza ☐Other: ____________			
†If prescribing Daurismo: ☐Cytarabine			
☐Dexamethasone ☐Hemady			
☐Pomalyst ☐Revlimid ☐Thalomid			N/A
For Pomalyst, Revlimid, Thalomid: ☐Adult female – NOT of reproductive potential ☐Female child – NOT of reproductive potential ☐Adult male ☐Adult female – Reproductive potential ☐Female child – Reproductive potential ☐Male child Physician authorization #: ____________ Date: ____________ Pharmacy confirmation #: ____________ Date: ____________ **(For pharmacy use only)**			
☐Akynzeo ☐Aloxi ☐Anzemet ☐Emend ☐Sancuso ☐Zofran ☐Other: ____________			
☐Granix ☐Leukine ☐Neupogen ☐Neulasta ☐Zarxio ☐Other: ____________			
☐Aranesp ☐Procrit ☐Other: ____________			
☐Arixtra ☐Fragmin ☐Heparin ☐Lovenox ☐Other: ____________			

* 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

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.

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Drug names are the property of their respective owners.

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