

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: \_\_\_\_\_ m² 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 NTRK Gene Fusion  Positive  Negative RET fusion  Positive  Negative RET mutant  Positive  Negative

Table with 4 columns: Medication, Dose/Directions/Frequency, Qty, Refills. Rows include Afinitor, Erleada, Koselugo\*, Nexavar, Rozlytrek, Tarceva, Xeloda, Zytiga, Other, Lenvima\*, Braftovi, Gleevec, Lonsurf, Nubega, Stivarga, Temodar, Xtandi, Cabometyx, Inlyta, Lysodren, Retevmo, Sutent, Votrient, Yonsa.

If prescribing:

Table with 4 columns: Medication, Dose/Directions/Frequency, Qty, Refills. Rows include Yonsa, Zytiga, Akynzeo, Emend, Other, Granix, Neulasta, Other, Aranesp, Other, Arixtra, Heparin, Other, Aloxi, Sancuso, Leukine, Zarxio, Procrit, Fragmin, Lovenox, Anzemet, Zofran, Neupogen.

\* 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.