Oncology

phone: 1.877.829.3137
fax: 1.417.869.0277

Patient Information

Patient Name: _____ DOB: _____
Sex ☐Female ☐Male SS #: _____
1° Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite:_____ City: _____ State: _____ Zip:_____
Phone: _____ Alternate Phone: _____
Caregiver Name: _____ Relation: _____
Local Pharmacy: _____ Phone: _____
Insurance Plan: _____ Plan ID#: _____
Please fax a copy front and back of the insurance card(s).

Prescriber + shipping information

Prescriber Name: _____
NPI #: _____
Address: _____
Apt/Suite:_____ City: _____ State: _____ Zip:_____
Contact: _____
Phone: _____ Alternate Phone: _____
Fax: _____
Email Address: _____
If shipping to prescriber: ☐1st Month ☐Always ☐Never

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10 (C00-D49):_____
Patient Type (if applicable):
☐adult female NOT of reproductive potential ☐child female NOT of reproductive potential
☐adult female of reproductive potential ☐child female of reproductive potential Date:_____
BRAF mutation present (if applicable) ☐V600E ☐V600K Any prior treatment: ☐No ☐Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐NKDA ☐Other: _____

Prescriber information

☐Cotellic™ Three 20 mg tablets (60 mg) for 21 days on, 7 days off
Quantity: 63 tablets Refills:_____

☐Zelboraf® Four 240 mg tablets (960 mg) every 12 hours
Quantity: 240 tablets Refills:_____

☐Kisqali Starting dose: Three (3) 200 mg tablets with food 21 days on, 7 days off
Dose Reduction: ____200 mg tablet(s) with food for 21 days on, 7 days off
Quantity: 63 or ____ tablets Refills:_____

With letrozole One 2.5 mg tablets daily for 28 days
Quantity 28 tablets Refills:_____

☐Ibrance® ☐100 mg tablet with food for 21 days on, 7 days off
☐125 mg tablet with food for 21 days on, 7 days off
Quantity 21 tablets Refills:_____

With letrozole One 2.5 mg tablets once daily
Quantity 28 tablets Refills:_____

☐Lonsurf® ☐15 mg/6.14 mg Quantity: _____ Refills: _____
☐20 mg/8.19 mg Quantity: _____ Refills: _____

Take _____mg (35 mg/m^2/dose) twice daily on days 1 through 5 and 8 through 12 for each 28-day cycle within on hour of completion of morning and evening meals (round to the closest 5 mg).

☐Ninlaro® One 4 mg cap daily on days 1, 8 and 15 of a 28-day cycle
Quantity: 3 capsules Refills:_____

☐Revlimid®* One 25 mg cap for 21 days on, 7 days off
Quantity: 21 capsules Refills:_____

☐dexamethasone One 40 mg cap daily on days 1, 8, 15 and 22 of a 28-day cycle
Quantity: 4 capsules Refills:_____

☐Zytiga® Four 250 mg tablets (1000 mg) once daily without food
Quantity: 120 tablets Refills:_____

With prednisone One 5 mg tablet twice daily with food
Quantity: 60 tablets Refills:_____

☐Afinitor®	☐Farydak®	☐Iressa®	☐Revlimid®**	☐Tagrisso™	☐Tykerb®	☐Zolinza®
☐Arimedex®	☐Femara®	☐Jadenu®	☐Sprycel®	☐Tamoxifen®	☐Votrient®	☐Zykadia™
☐Bosulif®	☐Gleevec®	☐Jakafi®	☐Sutent®	☐Tarceva®	☐Xalkori®	☐Zydelig™
☐Cometriq®	☐Hycamtin®	☐Mekinist®	☐Stivarga®	☐Tasigna®	☐Xeloda®	☐_____
☐Erivedge®	☐Imbruvica™	☐Nexavar®	☐Sylatron®	☐Temodar®	☐Xtandi®	
☐Exjade®*	☐Inlyta®	☐Pomalyst®**	☐Tafinlar®	☐Thalomid®**	☐Zelboraf®	

Strength(s): _____Directions: _____
_____
Quantity:_____ Refills: _____ **Authorization _____
Packaging: ☐Normal ☐Blister Pack

Prescriptions will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written:): _____

Prescriber's Signature:_____Date:_____

I authorize Dan's Discount Drug Mart and its representatives to act as an agent to initiate and execute the insurance prior authorization process.