

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).



Lung Cancer Prescription/Pharmacy Intake Form

Central Pharmacy: _____ Pharmacy: _____
Retail/Community 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

ALK gene rearrangement Positive Negative EGFR, exon 21 substitution Positive Negative
BRAF mutation, V600E Positive Negative EGFR, T790M mutation Positive Negative
EGFR, exon 19 deletion Positive Negative ROS1 Gene alteration Positive Negative

Table with 4 columns: Medication, Dose/Directions/Frequency, Qty, Refills. Lists various medications like Alecensa, Hycamtin, Lorbreina, 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

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.

Drug names are the property of their respective owners.