

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).



Other Cancers Prescription/Pharmacy Intake Form

Central 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: _____ 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:

Other:

KRAS Wild Type Positive Negative

Kit (CD117) Positive Negative

Table with 4 columns: Medication, Dose/Directions/Frequency, Qty, Refills. Rows include various cancer medications like Afinitor, Inlyta, Stivarga, etc.

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. 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.