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 not a prescription. Please submit prescriptions electronically or via fax along with this form.

Clinical Data by Cancer Type

Pharmacy: ______________________

Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

List of medications ordered **(this form is not a prescription)**: ______________________

Date Needed By: ______________________

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

Name of Insured: ______________________ Employer: ______________________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

ICD-10 code: ______________________ ICD-10 description: ______________________

☐Patient is new to therapy ☐Patient is currently on therapy Start date: ____________

Treatment history (or attach clinical notes reflecting history):

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

Weight: ________ ☐lb ☐kg Date: ____________ Height: ________ ☐in ☐cm Date: ____________ BSA: ____________ m^2

Allergies: ______________________

CANCER TYPES

Cancer type / marker	Status
Acute Lymphoblastic Leukemia (ALL):	
Philadelphia chromosome status	☐Positive ☐Negative ☐N/A
Acute Myeloid Leukemia (AML):	
FLT3 mutation	☐Positive ☐Negative ☐N/A
IDH2 mutation	☐Positive ☐Negative ☐N/A
Breast & Ovarian Cancer:	
BRCA mutation	☐Positive ☐Negative ☐N/A
PIK3CA mutation	☐Positive ☐Negative ☐N/A
Estrogen Receptor status	☐Positive ☐Negative ☐N/A
HER2 status	☐Positive ☐Negative ☐N/A
Progesterone Receptor status	☐Positive ☐Negative ☐N/A
Is patient postmenopausal? ☐Yes ☐No	
Chronic Lymphocytic Leukemia (CLL):	
17p deletion	☐Positive ☐Negative ☐N/A
Chronic Myeloid Leukemia (CML):	
Philadelphia chromosome status	☐Positive ☐Negative ☐N/A
T315I mutation	☐Positive ☐Negative ☐N/A
Colorectal Cancer:	
BRAF mutation, V600E	☐Positive ☐Negative ☐N/A
KRAS Wild Type	☐Positive ☐Negative ☐N/A
Lung Cancer:	
ALK gene rearrangement	☐Positive ☐Negative ☐N/A
BRAF mutation, V600E	☐Positive ☐Negative ☐N/A
Lung Cancer:	
EGFR, exon 19 deletion	☐Positive ☐Negative ☐N/A
EGFR, exon 21 substitution	☐Positive ☐Negative ☐N/A
EGFR, T790M mutation	☐Positive ☐Negative ☐N/A
MET exon 14 skipping	☐Positive ☐Negative ☐N/A
RET fusion	☐Positive ☐Negative ☐N/A
ROS1 gene alteration	☐Positive ☐Negative ☐N/A
Melanoma:	
BRAF mutation, V600E	☐Positive ☐Negative ☐N/A
BRAF mutation, V600K	☐Positive ☐Negative ☐N/A
Surgery date: ____________	
Myelodysplastic Syndrome (MDS) / Myeloproliferative diseases or Neoplasms:	
Deletion 5q	☐Positive ☐Negative ☐N/A
JAK2 status	☐Positive ☐Negative ☐N/A
PDGF Receptor Gene status	☐Positive ☐Negative ☐N/A
Other:	
D816V c-Kit	☐Positive ☐Negative ☐N/A
FIP1L1-PDGF receptor alpha fusion kinase	☐Positive ☐Negative ☐N/A
Kit (CD117)	☐Positive ☐Negative ☐N/A
NTRK Gene Fusion	☐Positive ☐Negative ☐N/A
RET fusion	☐Positive ☐Negative ☐N/A
RET mutant	☐Positive ☐Negative ☐N/A

PRESCRIBER INFORMATION

Prescriber’s name: ______________________ Practice/facility: ______________________

Address: ______________________ City: ____________ State: ________ Zip code: ____________

Office contact: ______________________ Phone: ____________ Fax: ____________

Email (optional): ______________________ Best time to call: ____________ Preferred method of contact: ☐Email ☐Phone ☐Fax

I certify that the above information is accurate to the best of my knowledge.

Prescriber or Authorized Healthcare Provider Signature Required: ______________________ Date: ____________

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