

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).



Blood 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

17p Deletion <input type="checkbox"/> Positive <input type="checkbox"/> Negative	IDH2 mutation <input type="checkbox"/> Positive <input type="checkbox"/> Negative
D816V c-Kit <input type="checkbox"/> Positive <input type="checkbox"/> Negative	JAK2 Status <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Deletion 5q <input type="checkbox"/> Positive <input type="checkbox"/> Negative	PDGFR gene re-arrangements <input type="checkbox"/> Positive <input type="checkbox"/> Negative
FIP1L1-PDGFRα fusion kinase <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Philadelphia Chromosome <input type="checkbox"/> Positive <input type="checkbox"/> Negative
FLT3 mutation <input type="checkbox"/> Positive <input type="checkbox"/> Negative	T315I mutation <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Medication	Dose/Directions/Frequency	Quantity	Refills
<input type="checkbox"/> Bosulif <input type="checkbox"/> Calquence* <input type="checkbox"/> Daurismo† <input type="checkbox"/> Gleevec <input type="checkbox"/> Idhifa <input type="checkbox"/> Inqovi <input type="checkbox"/> Inrebic <input type="checkbox"/> Intron A <input type="checkbox"/> Jakafi <input type="checkbox"/> Matulane <input type="checkbox"/> Ninlaro <input type="checkbox"/> Onureg <input type="checkbox"/> Rydapt <input type="checkbox"/> Scemblix <input type="checkbox"/> Sprycel <input type="checkbox"/> Targretin <input type="checkbox"/> Tasisna <input type="checkbox"/> Zolinza <input type="checkbox"/> Other: _____			
†If prescribing Daurismo: <input type="checkbox"/> Cytarabine			
<input type="checkbox"/> Dexamethasone <input type="checkbox"/> Hemady <input type="checkbox"/> Pomalyst <input type="checkbox"/> Revlimid <input type="checkbox"/> Thalomid			N/A
For Pomalyst, Revlimid, Thalomid: <input type="checkbox"/> Adult female – NOT of reproductive potential <input type="checkbox"/> Female child – NOT of reproductive potential <input type="checkbox"/> Adult male <input type="checkbox"/> Adult female – Reproductive potential <input type="checkbox"/> Female child – Reproductive potential <input type="checkbox"/> Male child Physician authorization #: _____ Date: _____ Pharmacy confirmation #: _____ Date: _____ (For pharmacy use only)			
<input type="checkbox"/> MuGard <input type="checkbox"/> Other: _____ <input type="checkbox"/> Akynzeo <input type="checkbox"/> Aloxi <input type="checkbox"/> Anzemet <input type="checkbox"/> Emend <input type="checkbox"/> Sancuso <input type="checkbox"/> Zofran <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Granix <input type="checkbox"/> Leukine <input type="checkbox"/> Neupogen <input type="checkbox"/> Neulasta <input type="checkbox"/> Zarxio <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Aranesp <input type="checkbox"/> Procrit <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Arixtra <input type="checkbox"/> Fragmin <input type="checkbox"/> Heparin <input type="checkbox"/> Lovenox <input type="checkbox"/> Other: _____			

* 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