

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE - FIRST DOSE  OFFICE - ALL DOSES  OTHER \_\_\_\_\_

PATIENT INFORMATION		
Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION		
Prescriber Name		
Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant		
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

**INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD**

CLINICAL INFORMATION		
ICD-10:	Locations:	BSA:
<b>Prior Failed Therapies</b>		
Radiation:	Dates of Treatment:	Reason if Not Eligible:
Surgery:	Dates of Treatment:	Reason if Not Eligible:
Medication:	Length of Treatment:	Reason for Discontinuing:
Contraindicated Medication:		Reason:
Patient Allergies:		
<input type="checkbox"/> Cancer is locally advanced	<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy	<input type="checkbox"/> Patient or patient's partner is of child bearing age <input type="checkbox"/> Patient or patient's partner is pregnant
Notes:		

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Odomzo®	200 mg Tablet	Take one tablet by mouth daily	_____	_____
<input type="checkbox"/> Mekinist®	2 mg Tablet	Take one tablet by mouth daily on an empty stomach	_____	_____
<input type="checkbox"/> Tafinlar®	<input type="checkbox"/> 50 mg Capsules <input type="checkbox"/> 75 mg Capsules	Take 150 mg twice daily (every 12 hours) by mouth on an empty stomach	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____

<b>Dispense As Written</b> (no stamps)	<b>Date</b>	<b>Substitution Permitted</b> (no stamps)	<b>Date</b>
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1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.  
 2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.  
 3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.  
 4. Prescribers must comply with any of their state-specific prescription requirements.