

PATIENT INFORMATION

Patient Name:		SSN:		DOB:	
Address:		City:		State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: <input type="radio"/> Male <input type="radio"/> Female	
Email Address:		Allergies:			
Primary Diagnosis:		Diagnosis (ICD-10):			

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
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PRESCRIPTION INFORMATION (or attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID[®] (<i>lenalidomide</i>) [†] <i>Complete lab section below</i>	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg	<input type="checkbox"/> Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle. <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-14, of a 21 day cycle. <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-14, of a 28 day cycle <input type="checkbox"/> Take _____ caps by mouth once a day continuously on days 1-28.		None
THALOMID[®] (<i>thalidomide</i>)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take _____ caps by mouth once daily at bedtime.		None
POMALYST[®] (<i>pomalidomide</i>)	<input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg	<input type="checkbox"/> Take _____ caps by mouth once daily on days 1-21, of a 28 day cycle.		None

Patient Type: Adult Female, Not of Reproductive Potential Adult Female, Reproductive Potential Female Child, Not of Reproductive Potential
 Female Child, Reproductive Potential Adult Male Male Child

Celgene Auth#: _____ Date Issued: _____

† Labs Date: _____ Serum Creatinine: _____ eGFR/CrCL: _____

XELODA[®] (<i>capecitabine</i>) ^{††} <i>Complete lab section above</i>	<input type="checkbox"/> 150 mg <input type="checkbox"/> 500 mg Total dose: _____mg	<input type="checkbox"/> Take total dose by mouth twice daily on days 1-14 of 21 day cycle. Repeat. <input type="checkbox"/> Take total dose twice daily in conjunction with radiation: <input type="checkbox"/> M-F <input type="checkbox"/> 7 days/week Radiation length of therapy: _____ <input type="checkbox"/> Other _____		
TEMODAR[®] (<i>temozolomide</i>) [*]	<input type="checkbox"/> Total dose: _____mg	<input type="checkbox"/> Take _____ mg by mouth once daily for 5 days every 28 days <input type="checkbox"/> Take _____ mg by mouth once daily in conjunction with radiation for _____ days Start Date _____ for _____ # of days a week. <input type="checkbox"/> Other _____		
Deferiprone	500 mg	<input type="checkbox"/> Take _____mg by mouth three times daily with or without food Recommended dosing 25mg/kg to 33mg/kg body weight three time a day. Total daily dose of 75mg/kg to 99mg/kg		
JADENU[™] (<i>deferasirox</i>) ^{* †} <input type="checkbox"/> Tablets <input type="checkbox"/> Sprinkle Granules	<input type="checkbox"/> 90 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	<input type="checkbox"/> Take _____mg by mouth once daily with or without a light meal.		
EXJADE[®] (<i>deferasirox</i>) ^{* †} Tablets for Suspension	<input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____mg by mouth once daily on an empty stomach at least 30 minutes before food.		
ZYTIGA[®] (<i>abiraterone acetate</i>) [*]	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg by mouth once daily.		
with PREDNISONE	_____mg	CRPC: Take 5 mg by mouth twice daily with food CSPC: Take 5 mg by mouth once daily with food		

AFINITOR[®] (<i>everolimus</i>) [*]	DAURISMO[™] (<i>glasdegib</i>)	IBRANCE[®] (<i>palbociclib</i>)	MEKTOV[®] (<i>binimetinib</i>)	PIQRAY[®] (<i>alpelisib</i>)	TARCEVA[®] (<i>erlotinib</i>) [*]	XALKORI[®] (<i>crizotinib</i>) [†]
AGRYLIN[®] (<i>anagrelide</i>) [*]	ERLEADA[™] (<i>apalutamide</i>)	INLYTA[®] (<i>avitinib</i>)	MYLOTARG[™] (<i>gemtuzumab ozogamicin</i>)	RYDAPT[™] (<i>midostaurin</i>)	TARGRETIN[®] (<i>bexarotene</i>) [*]	XTANDIF[®] (<i>enzalutamide</i>)
BESPONSA[®] (<i>incotuzumab ozogamicin</i>)	FARYDAK[™] (<i>panobinostat</i>)	KISQALIF[®] (<i>ribociclib</i>) [†]	NILANDRON[®] (<i>nilotamide</i>)	SPRYCEL[®] (<i>dasatinib</i>)	TASIGNA[®] (<i>nilotinib</i>)	YONSA[®] (<i>abiraterone acetate</i>)
BOSULIF[®] (<i>bosutinib</i>) [†]	FASLODEX[®] (<i>fluvestrant</i>) [*]	FEMARA[®] (<i>letrozole</i>) [†]	NINLARO[®] (<i>ixazomib</i>) [†]	SUTENT[®] (<i>sunitinib malate</i>)	TYKERB[®] (<i>lapatinib</i>) [*]	ZOLINZA[™] (<i>vorinostat</i>)
BRAFTOVI[®] (<i>encorafenib</i>)	FORTEO[®] (<i>teriparadide</i>) [*]	LORBRENA[®] (<i>lorlatinib</i>) [†]	ODOMZO[®] (<i>sonidegib</i>)	TAFINLAR[®] (<i>dabrafenib</i>)	VIZIMPRO[®] (<i>dacomitinib</i>)	ZYTIGA[®] (<i>abiraterone acetate</i>) [*]
CYTOXAN[®] (<i>cyclophosphamide</i>) [*]	GLEEVEC[®] (<i>imatinib</i>) ^{* †}	MEKINIST[™] (<i>trametinib</i>)	ONUREG[®] (<i>azacitidine</i>)	TALZENNA[™] (<i>talazoparib</i>)	VOTRIENT[®] (<i>pazopanib</i>)	<small>*AVAILABLE IN GENERIC</small>

Drug Name (write in one of the above): _____
 Dose: _____ Frequency: _____ Quantity: _____ Refills: _____

Drug Name (write in one of the above): _____
 Dose: _____ Frequency: _____ Quantity: _____ Refills: _____

Drug Name (write in one of the above): _____
 Dose: _____ Frequency: _____ Quantity: _____ Refills: _____

Start of Therapy Date: _____ **Ship To:** Patient MD Office

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution. Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	