

## PATIENT INFORMATION

Patient Name:		SSN:		DOB:	
Address:		City:	State:	Zip:	
Home Phone:	Cell:	Height:	Weight:	Gender:	Male Female
Email:		Allergies:			
Primary Diagnosis:		Secondary Diagnosis			

## 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® (lenalidomide) <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® (thalidomide)	<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® (pomalidomide)	<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: \_\_\_\_\_

† To prevent delays and minimize phone calls please provide the following labs: Serum Creatinine: \_\_\_\_\_ eGFR/CrCL: \_\_\_\_\_ Date: \_\_\_\_\_

XELODA® (capecitabine)*† <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® (temozolomide)*	<input type="checkbox"/> Total dose: _____ mg tablet	<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 tablet	<input type="checkbox"/> Take _____ mg by mouth three times daily with or without food Recommended dosing 25 mg/kg to 33mg/kg body weight three time a day. Total daily dose of 75mg/kg to 99mg/kg		
JADENU™ (deferasirox)* † <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® (deferasirox)* † 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® (abiraterone acetate)*	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg by mouth once daily.		
with PREDNISONE	_____ mg	<input type="checkbox"/> CRPC: Take 5 mg by mouth twice daily with food <input type="checkbox"/> CSPC: Take 5 mg by mouth once daily with food		
<b>Sorafenib</b>	200 mg tablets	400 mg (2 tablets) orally twice daily without food		

AFINITOR® (everolimus)*	CYTOXAN® (cyclophosphamide)*	GAVRETO® (pralsetinib)	LORBRENA® (lorlatinib)†	ONUREG® (azacitidine)	TALZENNA® (talazoparib)	XALKORI® (crizotinib)†
AGRYLIN® (anagrelide)*	DAURISMO™ (glasdegib)	GLEEVEC® (imatinib)*†	LENVIMA® (lenvatinib)	PIQRAY® (alpelisib)	TARCEVA® (erlotinib)*	XTANDI® (enzalutamide)
ALECENSA® (alecetinib)	ERIVEDGE™ (vismodegib)	IBRANCE® (palbociclib)	MEKINIST™ (trametinib)	ROZLYTREK® (erlotrectinib)	TARGRETIN® (bexarotene)*	YONSA® (abiraterone acetate)
BESPONSA® (moltuzumab ozogamicin)	ERLEADA™ (apalutamide)	INLYTA® (axitinib)	MEKTOV® (binimetinib)	RYDAPT® (midostaurin)	TASIGNA® (nilotinib)	ZELBORAF® (vemurafenib)
BOSULIF® (bosutinib) †	FARYDAK® (panobinostat)	KISQALI® (ribociclib) †	MYLOTARG™ (gemtuzumab ozogamicin)	SPRYCEL® (dasatinib)	TYKERB® (lapatinib)*	ZOLINZA™ (vorinostat)
BRAFTOVI® (encorafenib)	FASLODEX (fulvestrant)*	FEMARA® (letrozole)*	NILANDRON® (nilutamide)	SUTENT® (sunitinib maleate)	VIZIMPRO® (dacomitinib)	
COTELLIC® (cobimetinib)	FORTEO® (teriparatide)		ODOMZO® (sonidegib)	TAFINLAR® (dabrafenib)	VOTRIENT® (pazopanib)	

\*AVAILABLE IN GENERIC

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:	