

ORAL ONCOLOGY

PATIENT INFORMATION

Name:		SSN:	DOB:	
Address:		City:	State:	Zip:
Home Phone:	Cell:	Height:	Weight:	Gender: Female Male
Email:		Allergies:		
Primary Diagnosis (ICD-10):		Secondary 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® (lenalidomide) <sup>†</sup> <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 PO once a day on days 1-21, of a 28 day cycle. <input type="checkbox"/> Take _____ caps PO once a day on days 1-14, of a 21 day cycle. <input type="checkbox"/> Take _____ caps PO once a day on days 1-14, of a 28 day cycle <input type="checkbox"/> Take _____ caps PO 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 PO 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 PO 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

Cellgene Auth #: \_\_\_\_\_ Date Issued: \_\_\_\_\_

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

XELODA® (capecitabine)* <sup>†</sup> <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 PO twice daily on days 1-14 of 21 day cycle. Repeat. <input type="checkbox"/> Take total dose PO 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 PO once daily for 5 days every 28 days <input type="checkbox"/> Take _____ mg PO once daily in conjunction with radiation for _____ days <input type="checkbox"/> Start Date _____ for _____ # of days a week <input type="checkbox"/> Other _____		
Deferiprone	500 mg tablet	<input type="checkbox"/> Take _____ mg PO 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 PO once daily with or without a light meal.		
EXJADE® (deferasirox)* <sup>†</sup> Tablets for Suspension	<input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg PO 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 PO once daily.		
with PREDNISONE	<input type="checkbox"/> _____ mg	<input type="checkbox"/> CRPC: Take 5 mg PO twice daily with food <input type="checkbox"/> CSPC: Take 5 mg PO once daily with food		
Sorafenib	200 mg tablets	<input type="checkbox"/> 400 mg (2 tablets) PO twice daily without food		

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|-----------------------------------|------------------------------|-------------------------------------|-----------------------------------|------------------------------|------------------------------------|
| AFINITOR® (everolimus)*           | COMETRIQ™ (cabozantinib)     | FORTEO® (teriparatide)              | MEKINIST™ (trametinib)            | RYDAPT® (midostaurin)        | TASIGNA® (nilotinib)               |
| AGRYLIN® (anagrelide)*            | COTELLIC® (cobimetinib)      | GAVRETO® (pralsetinib)              | MEKTOVI® (binimetinib)            | SPRYCEL® (dasatinib)*        | TYKERB® (lapatinib)*               |
| ALECENSA® (alectinib)             | CYTOXAN® (cyclophosphamide)* | GLEEVEC® (imatinib)* <sup>†</sup>   | MYLOTARG™ (gemtuzumab ozogamicin) | SUTENT® (sunitinib maleate)* | VIZIMPRO® (dacomitinib)            |
| AUGTYRO™ (repotrectinib)          | DAURISMO™ (glasdegib)        | IBRANCE® (palbociclib)              | NILANDRON® (nilutamide)           | TABRECTA® (capmatinib)       | VOTRIENT® (pazopanib)              |
| BESPONSA® (motuzumab ozogamicin)  | ERIVEDGE™ (vismodegib)       | INLYTA® (axitinib)                  | ODOMZO® (sonidegib)               | TAFINLAR® (dabrafenib)       | XALKORI® (crizotinib) <sup>†</sup> |
| BOSULIF® (bosutinib) <sup>†</sup> | ERLEADA™ (apalutamide)       | KISQAL® (ribociclib)                | ONUREG® (azacitidine)             | TALZENNA® (talazoparib)      | XTANDI® (enzalutamide)             |
| BRAFTOVI® (encorafenib)           | FASLODEX® (fulvestrant)*     | LENVIMA® (lenvatinib)               | PIQRAY® (alpelisib)               | TARCEVA® (erlotinib)*        | YONSA® (abiraterone acetate)       |
| CABOMETYX® (cabozantinib)         | FEMARA® (letrozole)*         | LORBRENA® (lorlatinib) <sup>†</sup> | ROZLYTREK® (entrectinib)          | TARGETIN® (bexarotene)*      | ZELBORAF® (vemurafenib)            |

\*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: \_\_\_\_\_

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:	City:	State: Zip:
NPI #:	Tax ID #:	
Prescriber Signature:	Date:	