BioPlus® Specialty Pharmacy
A Carelon Company

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ORAL ONCOLOGY

Fax: 800-269-5493
Phone: 833-ONC-EASY (662-3279)
bioplusrx.com

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 #:

PRESCRIPTION INFORMATION (or attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID® *(lenalidomide)†* *Complete lab section below*	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	☐ Take _____ caps PO once a day on days 1-21, of a 28 day cycle ☐ Take _____ caps PO once a day on days 1-14, of a 21 day cycle ☐ Take _____ caps PO once a day on days 1-14, of a 28 day cycle ☐ Take _____ caps PO once a day continuously on days 1-28		None
THALOMID® *(thalidomide)*	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	☐ Take _____ caps PO once daily at bedtime		None
POMALYST® *(pomalidomide)*	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	☐ 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

Celgene Auth #: _____ **Date Issued:** _____

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

SPRYCEL® *(dasatinib)**	☐ 20 mg ☐ 50 mg ☐ 70 mg ☐ 80 mg ☐ 100 mg ☐ 140 mg	☐ Take _____mg PO once daily with or without a light meal		
GLEEVEC® *(imatinib)*†*	☐ 100 mg ☐ 400 mg	☐ Take _____ mg PO once daily without food		
XELODA® *(capecitabine)* †Complete lab section above*	☐ 150 mg ☐ 500 mg Total dose: _____mg	☐ Take total dose PO twice daily on days 1-14 of 21 day cycle. Repeat. ☐ Take total dose PO twice daily in conjunction with radiation: ☐ M-F ☐ 7 days/week Radiation length of therapy:_____ ☐ Other_____		
TEMODAR® *(temozolomide)**	☐ Total dose: _____mg tablet	☐ Take _____ mg PO once daily for 5 days every 28 days ☐ Take _____ mg PO once daily in conjunction with radiation for _____ days ☐ Start Date _____ for _____ # of days a week ☐ Other_____		
JADENU™ *(deferasirox)* †* ☐ Tablets ☐ Sprinkle Granules	☐ 90 mg ☐ 180 mg ☐ 360 mg	☐ Take _____mg PO once daily with or without a light meal		
EXJADE® *(deferasirox)* †* Tablets for Suspension	☐ 125 mg ☐ 250 mg ☐ 500 mg	☐ Take _____mg PO once daily on an empty stomach at least 30 minutes before food		
ZYTIGA® *(abiraterone acetate)**	☐ 250 mg ☐ 500 mg	☐ Take _____ mg PO once daily		
with PREDNISONE	_____mg	☐ CRPC: Take 5 mg PO twice daily with food ☐ CSPC: Take 5 mg PO once daily with food		

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

*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 handwrite "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:		