

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Address		Address	
City State ZIP		City State ZIP	
Main Phone	Alternate Phone	Phone	Fax
Social Security #		Contact Person	
Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	DEA #	NPI # License #

Clinical Information			
Primary Diagnosis		ICD-10	Secondary Diagnosis ICD-10
Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs	Height <input type="checkbox"/> ft <input type="checkbox"/> in	Metastatic Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes	HER2: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
BSA m2	Hormone Receptor: <input type="checkbox"/> ER Positive <input type="checkbox"/> ER Negative <input type="checkbox"/> PR Positive <input type="checkbox"/> PR Negative	Treatment Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuation of Therapy, Start Date: _____ / _____ / _____	
Prior Therapy		Length of Treatment	Reason for Discontinuing
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing

Prescription Information			Qty	Refills
Must Include Dose/Frequency/Cycle On and Off Days				
<input type="checkbox"/> Xeloda®	<input type="checkbox"/> 150 mg Tablet <input type="checkbox"/> 500 mg Tablet	<input type="checkbox"/> Take _____ mg by mouth every 12 hours for 14 days on, then 7 days off <input type="checkbox"/> Conjunction with radiation: Take _____ mg by mouth every 12 hours with radiation for _____ days a week for a total of _____ weeks <input type="checkbox"/> Other: _____	_____ 150 mg Tablet(s) _____ 500 mg Tablet(s)	_____ _____
<input type="checkbox"/> Temodar®	<input type="checkbox"/> 5 mg Capsule <input type="checkbox"/> 20 mg Capsule <input type="checkbox"/> 100 mg Capsule <input type="checkbox"/> 140 mg Capsule <input type="checkbox"/> 180 mg Capsule <input type="checkbox"/> 250 mg Capsule	<input type="checkbox"/> Take _____ mg by mouth once daily for 5 days on, then 23 days off <input type="checkbox"/> Conjunction with radiation: Take _____ mg by mouth once daily with radiation for _____ days a week for a total of _____ weeks <input type="checkbox"/> Other: _____	_____ 5 mg Capsule(s) _____ 20 mg Capsule(s) _____ 100 mg Capsule(s) _____ 140 mg Capsule(s) _____ 180 mg Capsule(s) _____ 250 mg Capsule(s)	_____ _____ _____ _____ _____ _____
<input type="checkbox"/> Other Drug Name:	Strength/Formulation:	Include Dose/Frequency/Cycle On and Off Days:		
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) Substitution Permitted

Date

Prescriber's Signature (no stamps) Dispense As Written

Date