

Injection Training: MD Office
 Pharmacy to Arrange

Ship To : Patient Home MD Office

MAIN POINT OF CONTACT

Name: _____
Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)

Name: _____ Phone: _____ Phone 2: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.
Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance: _____ Secondary Insurance: _____
ID#: _____ RxBin: _____ ID#: _____ RxBin: _____
RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis: _____ ICD10 Code: _____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

<input type="checkbox"/> Afinitor (everolimus)	<input type="checkbox"/> Sutent (sunitinib malate)
<input type="checkbox"/> Afinitor Disperz (everolimus)	<input type="checkbox"/> Tarceva (erlotinib HCl)
<input type="checkbox"/> Cabometyx (cabozantinib)	<input type="checkbox"/> Tasciga (nilotinib)
<input type="checkbox"/> Gleevec (imatinib mesylate)	<input type="checkbox"/> Votrient (pazopanib)
<input type="checkbox"/> Ibrance (palbociclib)	<input type="checkbox"/> Xeloda (capecitabine)
<input type="checkbox"/> Jakafi (ruxolitinib)	<input type="checkbox"/> Xtandi (enzalutamide)
<input type="checkbox"/> Nexavar (sorafenib)	<input type="checkbox"/> Zelboraf (vemurafenib)
<input type="checkbox"/> Sprycel (dasatinib)	<input type="checkbox"/> Zytiga (abiraterone)

RX 1: Drug Name/Strength: _____
Sig: _____
Qty: _____ Refills: _____

RX 2: Drug Name/Strength: _____
Sig: _____
Qty: _____ Refills: _____

RX 3: Drug Name/Strength: _____
Sig: _____
Qty: _____ Refills: _____

R **Allergies:** _____

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____ NPI#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

***Prescriber Signature:** _____ **Date:** _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.