

# ONCOLOGY REFERRAL FORM (A-X)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

## PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email		Alt Contact Phone

## PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice / Facility Name	Prescriber Name / Specialty				
Address			City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

**\* Please include a copy of the front and back of insurance card \***

## CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:	Date Medication Needed			
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)				
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:
Other/Concomitant Medications (please list)				
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)				
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)				
ICD-10 Code <input type="checkbox"/> Code: Description:				

## PRESCRIPTION INFORMATION - Please Escribe if required by state law

*In order for a brand name product to be dispensed, the prescriber must handwritten "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.*

### ORAL ONCOLOGY AGENTS

<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> Erivedge	<input type="checkbox"/> Gleevec	<input type="checkbox"/> Leukeran	<input type="checkbox"/> Pomalidomide	<input type="checkbox"/> Targretin
<input type="checkbox"/> Afinitor	<input type="checkbox"/> Erleada	<input type="checkbox"/> Gleostine	<input type="checkbox"/> Mekinist	<input type="checkbox"/> Rezerox	<input type="checkbox"/> Tasigna
<input type="checkbox"/> Afinitor Disperz	<input type="checkbox"/> Erlotinib	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Mercaptopurine	<input type="checkbox"/> Rydapt	<input type="checkbox"/> Temodar
<input type="checkbox"/> Alkeran	<input type="checkbox"/> Etoposide	<input type="checkbox"/> Hydroxyurea	<input type="checkbox"/> Mesnex	<input type="checkbox"/> Scemblix	<input type="checkbox"/> Temozolomide
<input type="checkbox"/> Anastrozole	<input type="checkbox"/> Everolimus	<input type="checkbox"/> Imatinib Mesylate	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Soltamox	<input type="checkbox"/> Toremifene Citrate
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Everolimus Soluble	<input type="checkbox"/> Inrebic	<input type="checkbox"/> Nilandron	<input type="checkbox"/> Sorafenib	<input type="checkbox"/> Tretinoin
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Exemestane	<input type="checkbox"/> Kisqali	<input type="checkbox"/> Nilutamide	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Tykerb
<input type="checkbox"/> Bexarotene	<input type="checkbox"/> Fareston	<input type="checkbox"/> Kisqali + Femara Co-Pack	<input type="checkbox"/> Nolvadex	<input type="checkbox"/> Sunitinib Malate	<input type="checkbox"/> Votrient
<input type="checkbox"/> Bicalutamide	<input type="checkbox"/> Farydak	<input type="checkbox"/> Lapatinib	<input type="checkbox"/> Odomzo	<input type="checkbox"/> Tabrecta	<input type="checkbox"/> Xeloda
<input type="checkbox"/> Capecitabine	<input type="checkbox"/> Femara	<input type="checkbox"/> Letrozole	<input type="checkbox"/> Onureg	<input type="checkbox"/> Tafinlar	<input type="checkbox"/> Xtandi
<input type="checkbox"/> Emcyt	<input type="checkbox"/> Gavreto	<input type="checkbox"/> Leucovorin	<input type="checkbox"/> Piqray	<input type="checkbox"/> Tarceva	<input type="checkbox"/> Xatmep

Dose: \_\_\_\_\_  Tablets  Capsules  Other: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

Directions: \_\_\_\_\_

### BMS REMS PRODUCTS

<b>REVLIMID*</b> <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 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	<b>Risk Category</b> <input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <input type="checkbox"/> ADULT Male <input type="checkbox"/> Female CHILD, NOT of Reproductive Potential <input type="checkbox"/> Female CHILD, Reproductive Potential <input type="checkbox"/> Male CHILD Celgene Auth #: _____ Date Issued: _____ Confirmation #: _____ Date Issued: _____
<b>THALOMID*</b> <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	
<b>POMALYST*</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	

Prescriber Signature _____	Date _____	Supervising Physician Signature (where required by state law) _____	Date _____
DAW (Dispense as Written) _____	Date _____	Brand Necessary (must handwritten) _____	

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**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.

# ONCOLOGY REFERRAL FORM (Y-Z)

PHONE 888.370.1724 | FAX 877.645.7514



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## PATIENT INFORMATION

Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email		Alt Contact Phone

## PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax			
Referral Contact Email	Office Phone	Office Fax			
Practice / Facility Name		Prescriber Name / Specialty			
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

**\* Please include a copy of the front and back of insurance card \***

## CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:		Date Medication Needed			
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)					
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> Code: Description:					

## PRESCRIPTION INFORMATION - Please Escribe if required by state law

In order for a brand name product to be dispensed, the prescriber must *handwrite* "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

## ORAL ONCOLOGY AGENTS

<input type="checkbox"/> Yonsa	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Zolanza	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Zykadia	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Zytiga	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Dose: _____	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules <input type="checkbox"/> Other: _____	Qty: _____	Refills: _____
Directions: _____			

## BMS REMS PRODUCTS

REVLIMID* <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	Risk Category
<input type="checkbox"/> Take 1 capsule PO once daily. <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. <input type="checkbox"/> Other: _____	<input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <input type="checkbox"/> ADULT Male <input type="checkbox"/> Female CHILD, NOT of Reproductive Potential <input type="checkbox"/> Female CHILD, Reproductive Potential <input type="checkbox"/> Male CHILD
THALOMID* <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	Celgene Auth #: _____
<input type="checkbox"/> Take 1 capsule PO once daily. <input type="checkbox"/> Other: _____	Date Issued: _____
POMALYST* <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg	Confirmation #: _____
<input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. <input type="checkbox"/> Other: _____	Date Issued: _____

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature (where required by state law) \_\_\_\_\_ Date \_\_\_\_\_

DAW (Dispense as Written) \_\_\_\_\_ Date \_\_\_\_\_ Brand Necessary (must *handwrite*) \_\_\_\_\_

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# ONCOLOGY REFERRAL FORM (A-V)

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PATIENT INFORMATION							
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language		
Address			City	State	ZIP		
Email		Home Phone	Work Phone		Cell Phone		
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT							
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email			Alt Contact Phone	

PRESCRIBER INFORMATION							
Name of Contact Sending Referral			Title		Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email			Office Phone		Office Fax		
Practice / Facility Name			Prescriber Name / Specialty				
Address			City		State	ZIP	
Prescriber State License #		DEA #	NPI #		Medicaid UPIN #		

**\* Please include a copy of the front and back of insurance card \***

CLINICAL INFORMATION - Please include applicable clinical chart notes							
Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:						Date Medication Needed	
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)							
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:		Date Provided:	Patient Height (cm/in):		Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)							
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)							
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)							
ICD-10 Code <input type="checkbox"/> Code:		Description:					

**PRESCRIPTION INFORMATION - Please Escribe if required by state law**  
*In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.*

ORAL ONCOLOGY AGENTS					
<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> Emcyt	<input type="checkbox"/> Gavreto	<input type="checkbox"/> Lenvima	<input type="checkbox"/> Nolvadex	<input type="checkbox"/> Tabrecta
<input type="checkbox"/> Afinitor	<input type="checkbox"/> Erivedge	<input type="checkbox"/> Gleevec	<input type="checkbox"/> Letrozole	<input type="checkbox"/> Odomzo	<input type="checkbox"/> Tafinlar
<input type="checkbox"/> Afinitor Disperz	<input type="checkbox"/> Erleada	<input type="checkbox"/> Gleostine	<input type="checkbox"/> Leucovorin	<input type="checkbox"/> Onureg	<input type="checkbox"/> Tarceva
<input type="checkbox"/> Alkeran	<input type="checkbox"/> Erlotinib	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Leukeran	<input type="checkbox"/> Piqray	<input type="checkbox"/> Targretin
<input type="checkbox"/> Anastrozole	<input type="checkbox"/> Etoposide	<input type="checkbox"/> Hydroxyurea	<input type="checkbox"/> Mektovi	<input type="checkbox"/> Rezerox	<input type="checkbox"/> Tasigna
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Everolimus	<input type="checkbox"/> Imatinib Mesylate	<input type="checkbox"/> Mercaptopurine	<input type="checkbox"/> Rydapt	<input type="checkbox"/> Temodar
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Everolimus Soluble	<input type="checkbox"/> Inrebic	<input type="checkbox"/> Mesnex	<input type="checkbox"/> Scemblix	<input type="checkbox"/> Temozolomide
<input type="checkbox"/> Bexarotene	<input type="checkbox"/> Exemestane	<input type="checkbox"/> Jakafi	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Soltamox	<input type="checkbox"/> Toremifene Citrate
<input type="checkbox"/> Bicalutamide	<input type="checkbox"/> Fareston	<input type="checkbox"/> Kisqali	<input type="checkbox"/> Nilandron	<input type="checkbox"/> Sorafenib	<input type="checkbox"/> Tretinoin
<input type="checkbox"/> Braftovi	<input type="checkbox"/> Farydak	<input type="checkbox"/> Kisqali + Femara Co-Pack	<input type="checkbox"/> Nilutamide	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Tykerb
<input type="checkbox"/> Capecitabine	<input type="checkbox"/> Femara	<input type="checkbox"/> Lapatinib	<input type="checkbox"/> Ninlaro	<input type="checkbox"/> Sunitinib Malate	<input type="checkbox"/> Votrient

Dose: \_\_\_\_\_  Tablets  Capsules  Other: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 Directions: \_\_\_\_\_

BMS REMS PRODUCTS		
<b>REVLIMID*</b> <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 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	<b>Risk Category</b> <input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <input type="checkbox"/> ADULT Male <input type="checkbox"/> Female CHILD, NOT of Reproductive Potential <input type="checkbox"/> Female CHILD, Reproductive Potential <input type="checkbox"/> Male CHILD Celgene Auth #: _____ Date Issued: _____ Confirmation #: _____ Date Issued: _____	
<b>THALOMID*</b> <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills		
<b>POMALYST*</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills		

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must handwrite)	

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# ONCOLOGY REFERRAL FORM (X-Z)

PHONE 888.370.1724 | FAX 877.645.7514



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PATIENT INFORMATION							
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language		
Address			City	State	ZIP		
Email		Home Phone	Work Phone		Cell Phone		
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT							
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email			Alt Contact Phone	

PRESCRIBER INFORMATION							
Name of Contact Sending Referral			Title		Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email			Office Phone		Office Fax		
Practice / Facility Name			Prescriber Name / Specialty				
Address			City	State	ZIP		
Prescriber State License #		DEA #	NPI #	Medicaid UPIN #			

**\* Please include a copy of the front and back of insurance card \***

CLINICAL INFORMATION - Please include applicable clinical chart notes							
Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:						Date Medication Needed	
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)							
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:		Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:		
Other/Concomitant Medications (please list)							
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)							
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)							
ICD-10 Code <input type="checkbox"/> Code:		Description:					

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ORAL ONCOLOGY AGENTS	
<input type="checkbox"/> Xeloda	<input type="checkbox"/> Other:
<input type="checkbox"/> Xtandi	<input type="checkbox"/> Other:
<input type="checkbox"/> Xatmep	<input type="checkbox"/> Other:
<input type="checkbox"/> Yonsa	<input type="checkbox"/> Other:
<input type="checkbox"/> Zolinza	<input type="checkbox"/> Other:
<input type="checkbox"/> Zykadia	<input type="checkbox"/> Other:
<input type="checkbox"/> Zytiga	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

Dose: \_\_\_\_\_  Tablets  Capsules  Other: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 Directions: \_\_\_\_\_

BMS REMS PRODUCTS			
<b>REVLIMID*</b> <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 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	<b>Risk Category</b> <input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <input type="checkbox"/> ADULT Male <input type="checkbox"/> Female CHILD, NOT of Reproductive Potential <input type="checkbox"/> Female CHILD, Reproductive Potential <input type="checkbox"/> Male CHILD Celgene Auth #: _____ Date Issued: _____ Confirmation #: _____ Date Issued: _____		
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<b>POMALYST*</b> <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills			

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature (where required by state law) \_\_\_\_\_ Date \_\_\_\_\_

DAW (Dispense as Written) \_\_\_\_\_ Date \_\_\_\_\_ Brand Necessary (must handwrite) \_\_\_\_\_

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PATIENT INFORMATION						
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language	
Address			City	State	ZIP	
Email	Home Phone		Work Phone		Cell Phone	
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT						
Primary Caregiver/Alt Contact Name (if applicable)			Alt Contact Email		Alt Contact Phone	
PRESCRIBER INFORMATION						
Name of Contact Sending Referral			Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email			Office Phone	Office Fax		
Practice / Facility Name			Prescriber Name / Specialty			
Address			City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #			
<b>* Please include a copy of the front and back of insurance card *</b>						
CLINICAL INFORMATION - Please include applicable clinical chart notes						
Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:				Date Medication Needed		
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)						
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:		Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)						
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)						
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)						
ICD-10 Code <input type="checkbox"/> Code: Description:						
PRESCRIPTION INFORMATION - Please Escribe if required by state law						
<i>In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.</i>						
ORAL ONCOLOGY AGENTS						
<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> Erivedge	<input type="checkbox"/> Gleevec	<input type="checkbox"/> Letrozole	<input type="checkbox"/> Odomzo	<input type="checkbox"/> Tarceva	<input type="checkbox"/> Votrient
<input type="checkbox"/> Afinitor	<input type="checkbox"/> Erleada	<input type="checkbox"/> Gleostine	<input type="checkbox"/> Leucovorin	<input type="checkbox"/> Onureg	<input type="checkbox"/> Targretin	<input type="checkbox"/> Xeloda
<input type="checkbox"/> Afinitor Disperz	<input type="checkbox"/> Erlotinib	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Leukeran	<input type="checkbox"/> Piqray	<input type="checkbox"/> Tassigna	<input type="checkbox"/> Xtandi
<input type="checkbox"/> Alkeran	<input type="checkbox"/> Etoposide	<input type="checkbox"/> Hydroxyurea	<input type="checkbox"/> Mekinist	<input type="checkbox"/> ReZurock	<input type="checkbox"/> Temodar	<input type="checkbox"/> Xatmep
<input type="checkbox"/> Anastrozole	<input type="checkbox"/> Everolimus	<input type="checkbox"/> Imatinib Mesylate	<input type="checkbox"/> Mercaptopurine	<input type="checkbox"/> Rydapt	<input type="checkbox"/> Temozolomide	<input type="checkbox"/> Yonsa
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Everolimus Soluble	<input type="checkbox"/> Inrebic	<input type="checkbox"/> Mesnex	<input type="checkbox"/> Scemblix	<input type="checkbox"/> Toremifene Citrate	<input type="checkbox"/> Zolanza
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Exemestane	<input type="checkbox"/> Jakafi	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Soltamox	<input type="checkbox"/> Tretinoin	<input type="checkbox"/> Zykadia
<input type="checkbox"/> Bexarotene	<input type="checkbox"/> Fareston	<input type="checkbox"/> Kisqali	<input type="checkbox"/> Nilandron	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Tykerb	<input type="checkbox"/> Zytiga
<input type="checkbox"/> Bicalutamide	<input type="checkbox"/> Farydak	<input type="checkbox"/> Kisqali + Femara Co-Pack	<input type="checkbox"/> Nilutamide	<input type="checkbox"/> Sunitinib Malate	<input type="checkbox"/> Votrient	<input type="checkbox"/> Other:
<input type="checkbox"/> Capecitabine	<input type="checkbox"/> Femara	<input type="checkbox"/> Lapatinib	<input type="checkbox"/> Ninlaro	<input type="checkbox"/> Tabrecta	<input type="checkbox"/> Xeloda	<input type="checkbox"/> Other:
<input type="checkbox"/> Emcyt	<input type="checkbox"/> Gavreto	<input type="checkbox"/> Lenvima	<input type="checkbox"/> Nolvadex	<input type="checkbox"/> Tafinlar	<input type="checkbox"/> Tykerb	<input type="checkbox"/> Other:
Dose: _____ <input type="checkbox"/> Tablets <input type="checkbox"/> Capsules <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____						
Directions: _____						
BMS REMS PRODUCTS						
REVLIMID* <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				Risk Category		
<input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills				<input type="checkbox"/> ADULT Female, NOT of Reproductive Potential		
<input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills				<input type="checkbox"/> ADULT Female, Reproductive Potential		
<input type="checkbox"/> Other: _____ QTY: ____ 0 Refills				<input type="checkbox"/> ADULT Male		
THALOMID* <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg				<input type="checkbox"/> Female CHILD, NOT of Reproductive Potential		
<input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills				<input type="checkbox"/> Female CHILD, Reproductive Potential		
<input type="checkbox"/> Other: _____ QTY: ____ 0 Refills				<input type="checkbox"/> Male CHILD		
POMALYST* <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg				Celgene Auth #: _____		
<input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills				Date Issued: _____		
<input type="checkbox"/> Other: _____ QTY: ____ 0 Refills				Confirmation #: _____		
				Date Issued: _____		

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature (where required by state law) \_\_\_\_\_ Date \_\_\_\_\_  
DAW (Dispense as Written) \_\_\_\_\_ Date \_\_\_\_\_ Brand Necessary (must handwrite) \_\_\_\_\_

**Note:** The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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