

1. DOCTOR/PRESCRIBER FILL OUT AND  
 FAX TO: 1-800-966-3057 or Call: 1-888-773-7376

- Faxes will only be accepted from a doctor's office.
- Class II medications cannot be faxed.

**Patient Information**  New Rx  Refill

Name: \_\_\_\_\_ Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_  
 Address: \_\_\_\_\_ Allergies: \_\_\_\_\_  No Known Allergies  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Health Conditions: \_\_\_\_\_  
 Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Expected Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Statement of Medical Necessity**

Patient Weight: \_\_\_\_\_  lbs  kg Primary Diagnosis: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_

**Drug Delivery Information** If this drug requires Prior Authorization, please send appropriate documentation (notes, test results, etc.)

In Office Delivery  Home Delivery for Self Injection/Administration  Home Delivery for Home Health Administration  
 Other: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

**Insurance Information** Complete here or fax a copy of the patient's insurance card (both sides). Medicare card is required.

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_  
 Insured: \_\_\_\_\_ Insured: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Rx Drug Card #: \_\_\_\_\_  
 RxBin #: \_\_\_\_\_ RxPCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_ RxBin #: \_\_\_\_\_ RxPCN #: \_\_\_\_\_ Rx Grp #: \_\_\_\_\_

**Doctor/Prescriber Information** NPI # is mandatory. DEA # is required if the prescription is for controlled substances or Medicare/Medicaid.

Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Address: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

2. COMPLETE THE FOLLOWING Rx FORM -OR- TAPE Rx HERE

Date: ____/____/____	
Rx	Directions for Use
<p style="text-align: center;"><b>Drug Name/Form/Strength</b></p> <p><input type="checkbox"/> Afinitor   <input type="checkbox"/> Exjade   <input type="checkbox"/> Gleevec   <input type="checkbox"/> Granisetron   <input type="checkbox"/> Hycamtin</p> <p><input type="checkbox"/> Mesna   <input type="checkbox"/> Nexavar   <input type="checkbox"/> Oforta   <input type="checkbox"/> Promacta</p> <p><input type="checkbox"/> Sprycel   <input type="checkbox"/> Votrient   <input type="checkbox"/> Xeloda   <input type="checkbox"/> Zolanza</p> <p><input type="checkbox"/> Sutent   <input type="checkbox"/> Tarceva   <input type="checkbox"/> Tassigna   <input type="checkbox"/> Temodar</p> <p><input type="checkbox"/> Tykerb   <input type="checkbox"/> Ondansetron</p> <p><input type="checkbox"/> Revlimid   <input type="checkbox"/> Thalomid</p> <p>Auth _____ Auth _____</p> <p><b>Revlimid Risk Category</b>   <input type="checkbox"/> Adult Female, NOT of Childbearing Potential</p> <p><input type="checkbox"/> Adult Female, Childbearing Potential   <input type="checkbox"/> Adult Male   <input type="checkbox"/> Male Child</p> <p><input type="checkbox"/> Female Child, NOT of Childbearing Potential   <input type="checkbox"/> Female Child, Childbearing Potential</p> <p><input type="checkbox"/> Neupogen   <input type="checkbox"/> Neulasta</p> <p>Other: _____</p>	<p>Dose: _____</p> <p>Route: _____</p> <p>Frequency/Rest Period: _____</p> <p>Day/Cycle: _____</p> <p>Quantity: _____ Refills: _____</p>
<p><b>Needles</b> Gauge: ____ Inches: ____ Quantity: ____ Refills: ____   <b>Syringes</b> Volume: ____ Inches: ____ Quantity: ____ Refills: ____</p>	
<p>X _____</p> <p>Doctor/Prescriber Signature – Dispense as Written  <b>Stamped signatures cannot be accepted</b></p>	<p>X _____</p> <p>Doctor/Prescriber Signature – Substitution Permissible  <b>Stamped signatures cannot be accepted</b></p>