Oncology

toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

Patient Name: ____________________ DOB: ____________
Sex ❑ Female ❑ Male SS #: ____________________
1° Language: ____________ Wt: ______ ❑ kg ❑ lbs Ht: _______ ❑ cm ❑ in
Address: ____________________
Apt/Suite: ________ City: ______________ State: ______ Zip: __________
Phone: ____________________ Alternate Phone: __________________
Caregiver Name: __________________ Relation: __________________
Local Pharmacy: _________________ Phone: ____________________
Insurance Plan: ___________________ Plan ID#: __________________
Please fax a copy front and back of the insurance card(s).

Prescriber + shipping information

Prescriber Name: ____________________
NPI #: ____________________
Address: ____________________
Apt/Suite: ________ City: ______________ State: ______ Zip: __________
Contact: ____________________
Phone: ____________________ Alternate Phone: __________________
Fax: ____________________
Email Address: ____________________
If shipping to prescriber: ❑ 1st Month ❑ Always ❑ Never

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10 (C00-D49):____________________
Patient Type (if applicable):
❑ adult female NOT of reproductive potential ❑ child female NOT of reproductive potential
❑ adult female of reproductive potential ❑ child female of reproductive potential Date: ____________
BRAF mutation present (if applicable) ❑ V600E ❑ V600K Any prior treatment: ❑ No ❑ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: ____________________
Concomitant Medications: ____________________
Allergies: ❑ NKDA ❑ Other: ____________________

Prescriber information

❑ Cotellic™ Three 20 mg tablets (60 mg) for 21 days on, 7 days off
Quantity: 63 tablets Refills: ______

❑ Zelboraf® Four 240 mg tablets (960 mg) every 12 hours
Quantity: 240 tablets Refills: ________

❑ Lonsurf® ❑ 15 mg/6.14 mg Quantity: ______ Refills: ______
❑ 20 mg/8.19 mg Quantity: ______ Refills: ______

Take _____mg (35 mg/m²/dose) twice daily on days 1 through 5 and 8 through 12 for each 28-day cycle within on hour of completion of morning and evening meals (round to the closest 5 mg).

❑ Kisqali Starting dose: Three (3) 200 mg tablets with food 21 days on, 7 days off
Dose Reduction: ____200 mg tablet(s) with food for 21 days on, 7 days off
Quantity: 63 or ____ tablets Refills: ______
With letrozole One 2.5 mg tablets daily for 28 days
Quantity 28 tablets Refills: ______

❑ Ninlaro® One 4 mg cap daily on days 1, 8 and 15 of a 28-day cycle
Quantity: 3 capsules Refills: ______

❑ Revlimid®* One 25 mg cap for 21 days on, 7 days off
Quantity: 21 capsules Refills: ______

❑ dexamethasone One 40 mg cap daily on days 1, 8, 15 and 22 of a 28-day cycle
Quantity: 4 capsules Refills: ______

❑ Ibrance® 100 mg capsule with food for 21 days on, 7 days off
125 mg capsule with food for 21 days on, 7 days off
Quantity 21 capsule Refills: ______
With letrozole One 2.5 mg tablets once daily
Quantity 28 tablets Refills: ______

❑ Zytiga® Four 250 mg tablets (1000 mg) once daily without food
Quantity: 120 tablets Refills: ______
With prednisone One 5 mg tablet twice daily with food
Quantity: 60 tablets Refills: ______

❑ Afinitor®	❑ Farydak®	❑ Iressa®	❑ Revlimid®**	❑ Tafinlar®	❑ Thalomid®**	❑ Zelboraf®
❑ Arimedex®	❑ Femara®	❑ Jadenu®	❑ Rydapt ®	❑ Tagrisso™	❑ Tykerb®	❑ Zolinza®
❑ Bosulif®	❑ Gleevec®	❑ Jakafi®	❑ Sprycel®	❑ Tamoxifen®	❑ Votrient®	❑ Zykadia™
❑ Cometriq®	❑ Hycamtin®	❑ Mekinist®	❑ Sutent®	❑ Tarceva®	❑ Xalkori®	❑ Zydelig™
❑ Erivedge®	❑ Imbruvica™	❑ Nexavar®	❑ Stivarga®	❑ Tasigna®	❑ Xeloda®	❑ _________
❑ Exjade®*	❑ Inlyta®	❑ Pomalyst®**	❑ Sylatron®	❑ Temodar®	❑ Xtandi®	

Strength(s): ____________________ Directions: ____________________

Quantity: ____________________ Refills: ____________________ **Authorization ____________________
Packaging: ❑ Normal ❑ Blister Pack

Prescriptions will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written:): ____________

Prescriber's Signature: ____________________ Date: ______________
I authorize Thrifty White Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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