



Rx Order Form Oncology

Fax to 626-999-3236

Patient Information		Prescriber Information	
Patient Name: _____		Prescriber Name: _____	
Address: _____		Address: _____	
City, State, Zip: _____		City, State, Zip: _____	
Home Phone: _____		Phone: _____ Fax: _____	
Cell Phone: _____		DEA: _____ NPI: _____	
DOB: _____ Gender: ☐ M ☐ F		Contact Person: _____	
Weight: _____ lbs.	Height: _____	Allergies: ☐ NKDA ☐ Specify: _____	
Insurance Information			
(Please fax a copy of both sides for both pharmacy and medical cards)			
Primary Insurance: _____		ID#: _____	Group: _____
Secondary Insurance: _____		ID#: _____	Group: _____
Prescription Card: _____	ID#: _____	BIN#: _____	PCN#: _____ Group: _____
Diagnosis / ICD-10			
(Please fax relevant clinical notes, labs, tests, and previous medical history to expedite prior authorization)			
Diagnosis: _____		ICD-10: _____	
Medication Order			
☐ Abiraterone Acetate	☐ Erleada	☐ Hydroxyurea	☐ Mylotarg
☐ Afinitor	☐ Erlotinib	☐ Imatinib Mesylate	☐ Nilandron
☐ Afinitor Disperz	☐ Etoposide	☐ Inrebic	☐ Nilutamide
☐ Alkeran	☐ Everolimus	☐ Lapatinib	☐ Ninlaro
☐ Anastrozole	☐ Everolimus Sol.	☐ Lenvima	☐ Nolvadex
☐ Arimidex	☐ Exemestane	☐ Letrozole	☐ Odomzo
☐ Aromasin	☐ Fareston	☐ Leucovorin	☐ Onureg
☐ Besponsa	☐ Farydak	☐ Leukeran	☐ Piqray
☐ Bexarotene	☐ Femara	☐ Mekinist	☐ POMALYST (Rems)
☐ Bicalutamide	☐ Gleevec	☐ Mercaptopurine	☐ REVLIMID (Rems)
☐ Bosulif	☐ Gleostine	☐ Mesnex	☐ Rydapt
☐ Capecitabine	☐ Hycamtin	☐ Methotrexate	☐ Soltamox
			☐ Sorafenib
			☐ Sprycel
			☐ Sunitinib Malate
			☐ Sutent
			☐ Tabrecta
			☐ Tafenlar
			☐ Tarceva
			☐ Targretin
			☐ Tassigna
			☐ Toremifene Citrate
			☐ Tretinoin
			☐ Votrient
			☐ Xeloda
			☐ Xtandi
			☐ Xatmep
			☐ Yonsa
			☐ Zolanza
			☐ Zykadia
			☐ Zytiga
			☐ Other ↓
Other Drug: _____			
Prescription Details			
Dose: _____	☐ Tablets ☐ Capsules ☐ Other: _____		Qty: _____ Refills: _____
Directions: _____			
Clinical Information			
(Please include applicable chart notes)			
Patient New to Therapy? ☐ Yes ☐ No	Start Date: _____		Date Needed: _____
Treatment History or Failed Therapies: _____			
Sample/Starter Provided? ☐ Yes ☐ No	Provided Qty: _____	Date Provided: _____	
Other/Concomitant Medications: _____			
Delivery			
☐ Ship to Patient	☐ Ship to Provider Office	☐ Other: _____	
By signing below, I certify that the above therapy is medically necessary and substitution is authorized unless noted otherwise.			
_____ Provider Signature	_____ Date	_____ Notes	

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