

Ship To:  Patient  Physician/Clinic Date Shipment Needed: \_\_\_\_\_ Rx:  New  Refill

PATIENT INFORMATION

Date: \_\_\_\_\_ Patient SS#: \_\_\_\_\_ **DIAGNOSIS DESCRIPTION:** \_\_\_\_\_ **ICD9 CODE:** \_\_\_\_\_  
 Adult Male  Child Male  Adult Female - Non Childbearing  Adult Female - Childbearing  
 Female Child - Non Childbearing  Female Child - Childbearing  
 Patient's First Name: \_\_\_\_\_ Patient's Last Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_ lbs. Recorded Date: \_\_\_\_\_  
 Allergies: \_\_\_\_\_

**INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)**

**IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY:** \_\_\_\_\_

PRESCRIPTION

**ORAL ONCOLYTICS**

Afinitor <input type="checkbox"/>	Arimidex <input type="checkbox"/>	Femara <input type="checkbox"/>
Gleevec <input type="checkbox"/>	Hycamtin <input type="checkbox"/>	Nexavar <input type="checkbox"/>
Revlimid** <input type="checkbox"/>	Sprycel <input type="checkbox"/>	Sutent <input type="checkbox"/>
Tamoxifen <input type="checkbox"/>	Tarceva <input type="checkbox"/>	Tasigna <input type="checkbox"/>
Thalomid** <input type="checkbox"/>	Tykerb <input type="checkbox"/>	Votrient <input type="checkbox"/>
Zolanza <input type="checkbox"/>		Xeloda <input type="checkbox"/>

**Dosing & SIG:**  
  
 Refill #: \_\_\_\_\_  
**\*\*Authorization #:** \_\_\_\_\_

Zelboraf  BRAF V600E mutation positive as detected by an FDA-approved test? \_\_\_Yes \_\_\_No

Zytiga  Qty: \_\_\_\_\_ 250mg 4QD w/o food  
 WITH Prednisone Qty: \_\_\_ 5mg BID w/food

Refill #: \_\_\_\_\_ Zytiga Refill #: \_\_\_\_\_ Prednisone

**SUPPORT DRUGS**

Aranesp <input type="checkbox"/>	Arixtra <input type="checkbox"/>	Caphosol <input type="checkbox"/>
Emend <input type="checkbox"/>	Lovenox <input type="checkbox"/>	Neupogen <input type="checkbox"/>
Nplate* <input type="checkbox"/>	Procrit <input type="checkbox"/>	Promacta <input type="checkbox"/>
Zofran <input type="checkbox"/>	<b>* Call for ordering procedure</b>	

**Dosing & SIG:**  
  
 Refill #: \_\_\_\_\_

Qutenza  Qty: \_\_\_\_\_ (up to 4 patches)  
 WITH Lidocaine 4% cream  
 WITH Prilocaine 2.5% / Lidocaine 2.5% cream

**Complete this section ONLY if you would like Diplomat Pharmacy to initiate a Prior Authorization or Appeal on your behalf:**

PREVIOUS THERAPIES

PRIOR THERAPY Drug	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	<input type="checkbox"/> Disease Progression <input type="checkbox"/> Finished Therapy <input type="checkbox"/> Toxicity _____	_____ _____

PRESCRIBER

Physician's name: (please print) \_\_\_\_\_ Contact Person: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 License# \_\_\_\_\_ NPI# \_\_\_\_\_ UPIN# \_\_\_\_\_ MEDICAID Provider# \_\_\_\_\_  
 I authorize Diplomat Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.  
 Physician's signature: \_\_\_\_\_ M.D. DEA# \_\_\_\_\_