

**ORAL ONCOLOGY**

**PATIENT INFORMATION**

Name:		SSN:	DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: Female Male
Email:		Allergies:		
Primary Diagnosis (ICD-10):		Secondary Diagnosis (ICD-10):		

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
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**PRESCRIPTION INFORMATION (or attach a copy of prescription)**

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID® (lenalidomide) <sup>†</sup> Complete lab section below	<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 _____ caps PO once a day on days 1-21, of a 28 day cycle <input type="checkbox"/> Take _____ caps PO once a day on days 1-14, of a 21 day cycle <input type="checkbox"/> Take _____ caps PO once a day on days 1-14, of a 28 day cycle <input type="checkbox"/> Take _____ caps PO once a day continuously on days 1-28		None
THALOMID® (thalidomide)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take _____ caps PO once daily at bedtime		None
POMALYST® (pomalidomide)	<input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg	<input type="checkbox"/> Take _____ caps PO once daily on days 1-21, of a 28 day cycle		None

**Patient Type:**    Adult Female, Not of Reproductive Potential    Adult Female, Reproductive Potential    Female Child, Not of Reproductive Potential  
 Female Child, Reproductive Potential    Adult Male    Male Child

**Celgene Auth #:** \_\_\_\_\_   **Date Issued:** \_\_\_\_\_

† To prevent delays and minimize phone calls please provide the following labs: Serum Creatinine: \_\_\_\_\_ eGFR/CrCL: \_\_\_\_\_ Date: \_\_\_\_\_

SPRYCEL® (dasatinib)*	<input type="checkbox"/> 20 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 70 mg <input type="checkbox"/> 80 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 140 mg	<input type="checkbox"/> Take _____ mg PO once daily with or without a light meal		
GLEEVEC® (imatinib)* <sup>†</sup>	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/> Take _____ mg PO once daily without food		
XELODA® (capecitabine)* <sup>†</sup> Complete lab section above	<input type="checkbox"/> 150 mg <input type="checkbox"/> 500 mg Total dose: _____ mg	<input type="checkbox"/> Take total dose PO twice daily on days 1-14 of 21 day cycle. Repeat. <input type="checkbox"/> Take total dose PO twice daily in conjunction with radiation: <input type="checkbox"/> M-F <input type="checkbox"/> 7 days/week   Radiation length of therapy: _____ <input type="checkbox"/> Other _____		
TEMODAR® (temozolomide)*	Total dose: _____ mg tablet	<input type="checkbox"/> Take _____ mg PO once daily for 5 days every 28 days <input type="checkbox"/> Take _____ mg PO once daily in conjunction with radiation for _____ days <input type="checkbox"/> Start Date _____ for _____ # of days a week <input type="checkbox"/> Other _____		
JADENU™ (deferasirox)* † Tablets <input type="checkbox"/> Sprinkle Granules	<input type="checkbox"/> 90 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	<input type="checkbox"/> Take _____ mg PO once daily with or without a light meal		
EXJADE® (deferasirox)* † Tablets for Suspension	<input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg PO once daily on an empty stomach at least 30 minutes before food		
ZYTIGA® (abiraterone acetate)*	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg PO once daily		
with PREDNISONE <input type="checkbox"/> Rx sent to local pharmacy	_____ mg	<input type="checkbox"/> CRPC: Take 5 mg PO twice daily with food <input type="checkbox"/> CSPC: Take 5 mg PO once daily with food		

AFINITOR® (everolimus)*	COTELLIC® (cobimetinib)	GAVRETO® (pralsetinib)	MEKTOVI® (binimetinib)	ROZLYTREK® (entrectinib)	TASIGNA® (nilotinib)
AGRYLIN® (anagrelide)*	CYTOXAN® (cyclophosphamide)*	IBRANCE® (palbociclib)	MYLOTARG™ (gemtuzumab ozogamicin)	RYDAPT® (midostaurin)	TYKERB® (lapatinib)*
ALECENSA® (alectinib)	DAURISMO™ (glasdegib)	IDHIFA® (enasidenib)	NILANDRON® (nilutamide)	SORAFENIB™	VIZIMPRO® (dacomitinib)
AUGTYRO™ (repotrectinib)	DEFERIPRONE™	INLYTA® (axitinib)	ODOMZO® (sonidegib)	SUTENT® (sunitinib malate)*	VOTRIENT® (pazopanib)
BESPONSA® (inotuzumab ozogamicin)	ERIVEDGE™ (vismodegib)	ITOVEBI™ (inavolisib)	OPDIVO QVANTIG™	TABRECTA® (capmatinib)	XALKORI® (crizotinib) <sup>†</sup>
BOSULIF® (bosutinib) †	ERLEADA™ (apalutamide)	KISQALI® (ribociclib)	(nivolumab and hyaluronidase-nvny)	TAFINLAR® (dabrafenib)	XTANDI® (enzalutamide)
BRAFTOVI® (encorafenib)	FASLODEX® (fulvestrant)*	LENVIMA® (lenvatinib)	ONUREG® (azacitidine)	TALZENNA® (talazoparib)	YONSA® (abiraterone acetate)
CABOMETYX® (cabozantinib)	FEMARA® (letrozole)*	LORBRENA® (lorlatinib) <sup>†</sup>	PIQRAY® (alpelisib)	TARCEVA® (erlotinib)*	ZELBORAF® (vemurafenib)
COMETRIQ™ (cabozantinib)	FORTEO® (teriparatide)	MEKINIST™ (trametinib)	PROMACTA® (eltrombopag)	TARGETIN® (bexarotene)*	ZOLINZA™ (vorinostat)

\*AVAILABLE IN GENERIC

**Drug Name** (write in one of the above): \_\_\_\_\_  
 Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Drug Name** (write in one of the above): \_\_\_\_\_  
 Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Start of Therapy Date:** \_\_\_\_\_   **Ship To:**    Patient    MD Office

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.    Dispense as written

**PHYSICIAN INFORMATION**

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State:   ZIP:
NPI #:	Tax ID #:	
Prescriber Signature:	Date:	