

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

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID® (lenalidomide) [†] <i>Complete lab section below</i>	<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

Cellgene 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) [†]	<input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg	Take _____ mg PO once daily with food		
XELODA® (capecitabine)* [†] <i>Complete lab section above</i>	<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)* † <input type="checkbox"/> Tablets <input type="checkbox"/> Sprinkle Granules	<input type="checkbox"/> 90 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	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	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	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		
JAYPIRCA® (pirtobrutinib) Tablets	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg	Take _____ mg PO once daily		
RETEVMO® (selpercatinib) Tablets	<input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg <input type="checkbox"/> 120 mg <input type="checkbox"/> 160 mg	Take _____ mg PO twice daily		
VERZENIO® (abemaciclib) Tablets	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	Take _____ mg PO twice daily		

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 QUANTIG™	TABRECTA® (capmatinib)	XALKOR® (crizotinib) [†]
BOSULIF® (bosutinib) †	ERLEADA™ (apalutamide)	KISQALI® (ribociclib)	(nivolumab and hyaluronidase-nvhy)	TAFINLAR® (dabrafenib)	XTANDI® (enzalutamide)
BRAFTOVI® (encorafenib)	FASLODEX® (fulvestrant)*	LENVIMA® (lenvatinib)	ONUREG® (azacitidine)	TALZENNA® (talazoparib)	YONSA® (abiraterone acetate)
CABOMETYX® (cabozantinib)	FEMARA® (letrozole)*	LORBRENA® (lorlatinib) [†]	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:	