



PATIENT INFORMATION NEW TO THERAPY THERAPY CONTINUATION

Name: _____ M F Daytime Phone w/Area Code: _____
 Address: _____ Evening Phone w/Area Code: _____
 City: _____ State: _____ ZIP Code: _____ Cell Phone w/Area Code: _____
 DOB: _____ Patient Weight: _____ Patient Height: _____ PCP Name: _____
 Allergies: _____ PCP Phone w/ Area Code: _____
 Deliver medication to: Patient's home Prescriber's office **DATE NEEDED:** _____ Email: _____

INSURANCE INFORMATION (Please include copy of front and back of insurance card if possible):

Provider/Plan: _____ Phone w/Area Code: _____
 Patient's ID #: _____ Patient's Group #: _____
 Policyholder's Name (if not patient): _____
Secondary Insurance: _____ Phone w/Area Code: _____
 Patient's ID #: _____ Patient's Group #: _____
 Policyholder's Name (if not patient): _____

CLINICAL CRITERIA **REQUIRED** Please check all that apply.
 ICD-9 and Condition: _____ Other (explain): _____

Rx INFORMATION

Medication	Form	Strength	Qty	Dose	Directions/Freq	Refills
Alkeran®		2 mg				
Gleevec®						
Nexavar®						
Revlimid®	We participate in the RevAssist Pharmacy Network. Please obtain an authorization number from Celgene and then submit orders on Revlimid patient prescription form.					
Sprycel®						
Sutent®						
Tarceva®						
Targretin®						
Tasigna®						
Temodar®						
Thalomid® (auth# _____)						
Tykerb®		250 mg				
Xeloda®						

Print Prescriber's Name: _____ Office Contact: _____
 Practice Name: _____ State License #: _____
 UPIN: _____ NPI: _____ DEA # _____
 Address: _____ City: _____ State: _____ ZIP Code: _____
 Phone w/Area Code: _____ Fax w/Area Code: _____
 Substitution Permissible.* In order for a brand-name product to be dispensed, the prescriber must handwrite BRAND NECESSARY or BRAND MEDICALLY NECESSARY in the space below.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.
 Prescriber's Signature Required: _____ Date: _____

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Drug names are the property of their respective owners.