Prescription & Enrollment Form

Oncology (oral) (T-Z)

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name ____________________

Last name ____________________ Middle initial _____

Date of birth ______________ ❑ Male ❑ Female Last 4 digits of SSN __________

Street address ____________________ Apt # ________

City ____________________ State _______ Zip __________

Parent/guardian (if applicable) ____________________

Home phone ____________ Work phone ____________ Cell phone ____________

Evening phone ______________ E-mail address ____________________

Patient's primary language: ❑ English ❑ Other If other, please specify __________

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company ____________________ Phone ____________

Insured's name ____________________

Insured's employer ______________ Relationship to patient ____________

Identification # ______________ Policy/group # ______________

Prescription card: ❑ Yes ❑ No If yes, carrier ____________________

Policy # __________ Group # __________ Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date ______________ Time __________ Date medication needed ______________

Prescriber's first name ____________________ Last name ____________________

Prescriber's title ____________________

If NP or PA, under direction of Dr. ____________________

Office contact and title ____________________

Office contact e-mail ____________________

Office/clinic/institution name ____________________

Clinic/hospital affiliation ____________________

Street address ____________________ Suite # ________

City ____________________ State _______ Zip ________

Phone ____________________ Fax ____________________

NPI # ____________________ License # ____________________

3 CLINICAL INFORMATION

Primary ICD-10 code: ____________________

Current weight __________ kg/lbs Height __________ inches/cm

BSA __________ m² Date obtained ______________

❑ NKDA ❑ Known drug allergies ____________________

Concurrent meds ____________________

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Talzenna® (talazoparib)	❑ 0.25 mg capsule ❑ 1 mg capsule	❑ Take ________ mg by mouth daily ❑ Other ____________ A dose titration/reduction can be prescribed in order to manage tolerability.	Quantity ________ Days supply ________ Refills ________
❑ Tasigna® (nilotinib)	❑ 150 mg capsule (28 capsules per pack) ❑ 200 mg capsule (28 capsules per pack)	❑ Take ________ capsule(s) twice daily ❑ Other ____________	Qty of packs ________ Days supply ________ Refills ________
❑ Temodar® (temozolomide)	❑ 5 mg capsule ______ qty ❑ 20 mg capsule ______ qty ❑ 100 mg capsule ______ qty ❑ 140 mg capsule ______ qty ❑ 180 mg capsule ______ qty ❑ 250 mg capsule ______ qty	❑ Take _____ mg once daily for _____ days on and _____ days off ❑ Other ____________ Please see "Other" below to prescribe antiemetic agent if necessary.	Days supply ________ Refills ________
❑ Tykerb® (lapatinib)	❑ 250 mg tablet	❑ Take 5 tablets once daily ❑ Other ____________	Quantity ________ Days supply ________ Refills ________
❑ Vizimpro® (dacomitinib)	❑ 15 mg tablet ❑ 30 mg tablet ❑ 45 mg tablet	❑ Take _____ mg once daily ❑ Other ____________	Quantity ________ Days supply ________ Refills ________
❑ Votrient® (pazopanib)	❑ 200 mg tablet	❑ Take 4 tablets once daily ❑ Other ____________	Quantity ________ Days supply ________ Refills ________
❑ Xalkori® (crizotinib)	❑ 200 mg tablet ❑ 250 mg tablet	❑ Take one tablet twice daily ❑ Other ____________	Quantity ________ Days supply ________ Refills ________
❑ Xeloda® (capecitabine)	❑ 150 mg tablet ______ qty ❑ 500 mg tablet ______ qty	❑ Take _____ mg twice daily for _____ days with _____ days off ❑ Other ____________	Days supply ________ Refills ________
❑ Xtandi® (enzalutamide)	❑ 40 mg capsule	❑ Take 4 capsules once daily ❑ Other ____________	Quantity ________ Days supply ________ Refills ________
❑ Other ____________			Quantity ________ Days supply ________ Refills ________

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

______________ ____________________ ______________ ____________________

Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Oncology team at 888.302.1028. To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

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