

## 1 PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
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 \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Insurance Company Phone No. \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Identification No. \_\_\_\_\_ Policy/Group No. \_\_\_\_\_  
Prescription Card  No  Yes If Yes, Carrier \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Is patient eligible for Medicare?  No  Yes **Please attach front and back copy of patient's insurance cards, if available.**

## 2 PRESCRIBER INFORMATION

**All fields must be completed to expedite prescription fulfillment.**

Date \_\_\_\_\_ Time \_\_\_\_\_  
Prescriber's Name and Title \_\_\_\_\_  
Office Contact \_\_\_\_\_  
Clinic / Hospital Affiliation \_\_\_\_\_  
Street Address \_\_\_\_\_ Suite # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
NPI No. \_\_\_\_\_ License No. \_\_\_\_\_  
DEA No. \_\_\_\_\_  
Physician Medicaid UPIN No. \_\_\_\_\_  
MD Specialty \_\_\_\_\_

To reach your team, call toll-free **1 888 608-9010**.  
**Please fax completed form to the Oncology team**  
**1 888 302-1028.**

## 3 CLINICAL INFORMATION

ICD9 CODE \_\_\_\_\_  
Current Weight \_\_\_\_\_ kg Height \_\_\_\_\_ inches/cm BSA \_\_\_\_\_ m<sup>2</sup>  
\_\_\_\_\_ lbs  
Rx:  **Gleevec**® (imatinib mesylate)  **Sprycel**™ (dasatinib)  
 **Temodar**® (temozolomide)  **Thalomid**® (thalidomide)  
 **Tarceva**™ (erlotinib hydrochloride) Celgene Authorization # \_\_\_\_\_  
 **Tasigna**® (nilotinib)  **Sutent**® capsules (sunitinib malate)  
 **Zolinza**™ (vorinostat)  **Xeloda**® (capecitabine)  
Therapy Specific referral forms required for the following therapies. These forms can be found on our website at [www.accredo.com](http://www.accredo.com):  
**Tykerb**® (lapatinib) **Nexavar**® (sorafenib)  
**Revlimid**® (lenalidomide) **Exjade**® (deferasirox)

Strength(s) \_\_\_\_\_  
SIG: Dose: \_\_\_\_\_  
Directions (Include daily, weekly, cyclic, one-time, duration of therapy, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
 NKDA  Known Drug Allergies: \_\_\_\_\_  
**EXPECTED DATE OF FIRST/NEXT DOSE:** \_\_\_\_\_ Date of Last Dose? \_\_\_\_\_  
Deliver product to:  Office  Patient's Home  Clinic  
Clinic Location \_\_\_\_\_  
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

*By signing below, I certify that the above therapy is medically necessary.*  
**Prescriber's Printed Name** \_\_\_\_\_

**Prescriber's Signature (sign below)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Dispense as Written**

**Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS**)