

Prescription & Enrollment Form  
**Oncology (oral) (A-S)**



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 \_\_\_\_\_ m<sup>2</sup> Date obtained \_\_\_\_\_  
 NKDA  Known drug allergies \_\_\_\_\_  
 Concurrent meds \_\_\_\_\_

**4 PRESCRIBING INFORMATION**

| Medication  | Strength/Formulation  | Directions  | Quantity/Refills                                  |
|---|---|---|---|
| <input type="checkbox"/> abiraterone acetate            | <input type="checkbox"/> 250mg tablet<br><input type="checkbox"/> 500mg tablet  | <input type="checkbox"/> Take 1000mg (four 250mg tablets or two 500mg tablets) orally once daily<br><input type="checkbox"/> Other _____<br>If patient is NOT currently receiving prednisone, prescribe below in "Other." | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Afinitor® (everolimus)         | <input type="checkbox"/> 2.5mg tablet <input type="checkbox"/> 5mg tablet<br><input type="checkbox"/> 7.5mg tablet <input type="checkbox"/> 10mg tablet   | <input type="checkbox"/> Take one tablet daily<br><input type="checkbox"/> Other _____  | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Afinitor® DISPERZ (everolimus) | <input type="checkbox"/> 2mg tablet <input type="checkbox"/> 3mg tablet<br><input type="checkbox"/> 5mg tablet  | <input type="checkbox"/> Dissolve _____ tablet(s) in water and drink daily<br><input type="checkbox"/> Other _____  | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Erivedge® (vismodegib)         | <input type="checkbox"/> 150mg capsule  | <input type="checkbox"/> Take one capsule daily<br><input type="checkbox"/> Other _____   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> erlotinib                      | <input type="checkbox"/> 25mg tablet <input type="checkbox"/> 100mg tablet<br><input type="checkbox"/> 150mg tablet   | <input type="checkbox"/> Take one tablet daily<br><input type="checkbox"/> Other _____  | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> imatinib mesylate              | <input type="checkbox"/> 100mg tablet <input type="checkbox"/> 400mg tablet   | <input type="checkbox"/> Take _____ tablet(s) _____ time(s) a day<br><input type="checkbox"/> Other _____   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Jakafi® (ruxolitinib)          | <input type="checkbox"/> 5mg tablet <input type="checkbox"/> 10mg tablet<br><input type="checkbox"/> 15mg tablet <input type="checkbox"/> 20mg tablet<br><input type="checkbox"/> 25mg tablet   | <input type="checkbox"/> Take _____ tablet(s) twice daily<br><input type="checkbox"/> Other _____   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Lorbrena® (lorlatinib)         | <input type="checkbox"/> 25mg tablet <input type="checkbox"/> 100mg tablet  | <input type="checkbox"/> Take _____ mg once daily<br><input type="checkbox"/> Other _____   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Promacta® (eltrombopag)        | <input type="checkbox"/> 12.5mg tablet <input type="checkbox"/> 25mg tablet<br><input type="checkbox"/> 50mg tablet <input type="checkbox"/> 75mg tablet  | <input type="checkbox"/> Take _____ tablet(s) twice daily<br><input type="checkbox"/> Other _____   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Sprycel® (dasatinib)           | <input type="checkbox"/> 20mg tablet <input type="checkbox"/> 50mg tablet<br><input type="checkbox"/> 70mg tablet <input type="checkbox"/> 80mg tablet<br><input type="checkbox"/> 100mg tablet <input type="checkbox"/> 140mg tablet | <input type="checkbox"/> Take one tablet daily<br><input type="checkbox"/> Other _____  | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Sutent® (sunitinib malate)     | <input type="checkbox"/> 12.5mg capsule <input type="checkbox"/> 25mg capsule<br><input type="checkbox"/> 37.5mg capsule <input type="checkbox"/> 50mg capsule  | <input type="checkbox"/> Take one capsule daily continuously<br><input type="checkbox"/> Take _____ capsule(s) daily 4 weeks on and 2 weeks off<br><input type="checkbox"/> Other _____                                   | Quantity _____ Days supply _____<br>Refills _____ |
| <input type="checkbox"/> Other _____                    |   |   | Quantity _____ Days supply _____<br>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.

Physician'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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