Prescription & Enrollment Form

Oncology (oral) (T-Z)

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

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)	❑ 0.25mg capsule ❑ 1mg 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)	❑ 150mg capsule (28 capsules per pack) ❑ 200mg capsule (28 capsules per pack)	❑ Take ______ capsule(s) twice daily ❑ Other ______	Qty of packs ______ Days supply ______ Refills ______
❑ Temodar® (temozolomide)	❑ 5mg capsule ______ qty ❑ 20mg capsule ______ qty ❑ 100mg capsule ______ qty ❑ 140mg capsule ______ qty ❑ 180mg capsule ______ qty ❑ 250mg 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)	❑ 250mg tablet	❑ Take 5 tablets once daily ❑ Other ______	Quantity ______ Days supply ______ Refills ______
❑ Vizimpro® (dacomitinib)	❑ 15mg tablet ❑ 30mg tablet ❑ 45mg tablet	❑ Take ______ mg once daily ❑ Other ______	Quantity ______ Days supply ______ Refills ______
❑ Votrient® (pazopanib)	❑ 200mg tablet	❑ Take 4 tablets once daily ❑ Other ______	Quantity ______ Days supply ______ Refills ______
❑ Xalkori® (crizotinib)	❑ 200mg tablet ❑ 250mg tablet	❑ Take one tablet twice daily ❑ Other ______	Quantity ______ Days supply ______ Refills ______
❑ Xeloda® (capecitabine)	❑ 150mg tablet ______ qty ❑ 500mg tablet ______ qty	❑ Take ______ mg twice daily for ______ days with ______ days off ❑ Other ______	Days supply ______ Refills ______
❑ Xtandi® (enzalutamide)	❑ 40mg 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 808.650.6487. To reach your team, call toll-free 808.650.6488.

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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