Please fax both pages of completed form to your 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.

Prescription & Enrollment Form

Oncology (oral) (T–Z)

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient   Current patient

Patient's first name ______________ Last name ______________ Middle initial ______

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

Street address ______________ Apt # ______

City ______________ State ______________ Zip ______

Home phone ______________ Cell phone ______________ E-mail address ______________

Parent/guardian (if applicable) ______________

Home phone ______________ Cell phone ______________ E-mail address ______________

Alternate caregiver/contact ______________

Home phone ______________ Cell phone ______________ E-mail address ______________

OK to leave message with alternate caregiver/contact

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

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 address ______________

Office contact and title ______________

Office contact phone number ______________ 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: ______________

Weight ________ kg/lbs Height ________ cm/in BSA ________ m^2 Date recorded ________

NKDA   Known drug allergies ______________

Concurrent meds ______________

Patient's first name ______ Last name ______ Middle initial ______ Date of birth ______

Prescriber's first name ______ Last name ______ Phone ______

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Talzenna® (talazoparib)	0.25mg capsule 0.5mg capsule 0.75mg 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 ______	Quantity ______ Days supply ______ Refills ______
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 ______
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 ______
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 ______

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

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

SIGN HERE

______ **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.

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