

Ship to:  Patient  Physician / Clinic Date Shipment Needed: \_\_\_\_\_ Rx:  New  Refill \_\_\_\_\_

### PATIENT INFORMATION

Patient's Full Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_  
 Alternate Phone: \_\_\_\_\_  
 Patient's Social Security Number: \_\_\_\_\_  
 Patient's Date of Birth: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Patient's Gender (Male or Female): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD10 Code: \_\_\_\_\_  
 Patient Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Primary Insurance: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Secondary Insurance: \_\_\_\_\_  
 ID #: \_\_\_\_\_ Phone: \_\_\_\_\_

OR PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

### PRESCRIPTION INFORMATION

Pomalyst  Revlimid  Thalomid  Female Child - NOT of Reproductive Potential  Adult Female - NOT of Reproductive Potential  
 Dose: \_\_\_\_\_ Qty: \_\_\_\_\_ Sig: \_\_\_\_\_  Female Child - Reproductive Potential  Adult Female - Reproductive Potential  
 Male Child  Adult Male  
 Authorization: \_\_\_\_\_ Date: \_\_\_\_\_ Confirmation #: \_\_\_\_\_ Date: \_\_\_\_\_ (Pharmacy Use Only)  
 Dexamethasone Dose: \_\_\_\_\_ Qty: \_\_\_\_\_ Directions: \_\_\_\_\_

Zytiga 250mg 4 QD (on empty stomach) Qty: \_\_\_\_\_ Refill: \_\_\_\_\_  
 WITH Prednisone 5mg BID with food Qty: \_\_\_\_\_ Refill: \_\_\_\_\_

I.V.I.G.

### ORAL DRUGS

- |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Afinitor  | <input type="checkbox"/> Kisqali   | <input type="checkbox"/> Odomzo    | <input type="checkbox"/> Tykerb    |
| <input type="checkbox"/> Arimidex  | <input type="checkbox"/> Hycamtin  | <input type="checkbox"/> Pomalyst  | <input type="checkbox"/> Venclexta |
| <input type="checkbox"/> Aromasin  | <input type="checkbox"/> Ibrance   | <input type="checkbox"/> Revlimid  | <input type="checkbox"/> Votrient  |
| <input type="checkbox"/> Bosulif   | <input type="checkbox"/> Imbruvica | <input type="checkbox"/> Rydapt    | <input type="checkbox"/> Xalkori   |
| <input type="checkbox"/> Cabometyx | <input type="checkbox"/> Inlyta    | <input type="checkbox"/> Sprycel   | <input type="checkbox"/> Xeloda    |
| <input type="checkbox"/> Cometriq  | <input type="checkbox"/> Iressa    | <input type="checkbox"/> Stivarga  | <input type="checkbox"/> Xtandi    |
| <input type="checkbox"/> Cotellic  | <input type="checkbox"/> Jadenu    | <input type="checkbox"/> Sutent    | <input type="checkbox"/> Zelboraf  |
| <input type="checkbox"/> Erivedge  | <input type="checkbox"/> Jakafi    | <input type="checkbox"/> Tamoxifen | <input type="checkbox"/> Zolanza   |
| <input type="checkbox"/> Evista    | <input type="checkbox"/> Lonsurf   | <input type="checkbox"/> Tafinlar  | <input type="checkbox"/> Zydelig   |
| <input type="checkbox"/> Fareston  | <input type="checkbox"/> Mekinist  | <input type="checkbox"/> Tagrisso  | <input type="checkbox"/> Zykadia   |
| <input type="checkbox"/> Farydak   | <input type="checkbox"/> Nexavar   | <input type="checkbox"/> Tarceva   | <input type="checkbox"/> Zytiga    |
| <input type="checkbox"/> Faslodex  | <input type="checkbox"/> Ninlaro   | <input type="checkbox"/> Tasisa    |                                    |
| <input type="checkbox"/> Femara    | <input type="checkbox"/> Nolvadex  | <input type="checkbox"/> Temodar   |                                    |
| <input type="checkbox"/> Gleevec   | <input type="checkbox"/> Noxafil   | <input type="checkbox"/> Thalomid  |                                    |

### DOSE/QUANTITY/DIRECTION:

Refill #: \_\_\_\_\_

### INJECTABLES

- |                                  |                                      |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Aranesp | <input type="checkbox"/> Neulasta    |
| <input type="checkbox"/> Arixtra | <input type="checkbox"/> Neupogen    |
| <input type="checkbox"/> Epogen  | <input type="checkbox"/> Nplate      |
| <input type="checkbox"/> Folotyn | <input type="checkbox"/> Perjeta     |
| <input type="checkbox"/> Fragmin | <input type="checkbox"/> Procrit     |
| <input type="checkbox"/> Leukine | <input type="checkbox"/> Retacrit    |
| <input type="checkbox"/> Lovenox | <input type="checkbox"/> Sandostatin |
| <input type="checkbox"/> Lupron  | <input type="checkbox"/> Sylatron    |

### IV INFUSION

- |   |
|---|
| <input type="checkbox"/> 5FU (Fluorouracil) |
| <input type="checkbox"/> Alimta             |
| <input type="checkbox"/> Avastin            |
| <input type="checkbox"/> Cyclophosphamide   |
| <input type="checkbox"/> Darzalex           |
| <input type="checkbox"/> Doxorubicin        |
| <input type="checkbox"/> Empliciti          |
| <input type="checkbox"/> Erbitux            |
| <input type="checkbox"/> Gazyva             |
| <input type="checkbox"/> Herceptin          |
| <input type="checkbox"/> Kadcyca            |
| <input type="checkbox"/> Keytruda           |
| <input type="checkbox"/> Reclast            |
| <input type="checkbox"/> Rituxan            |
| <input type="checkbox"/> Taxotere           |

### SUPPORT DRUGS

- |  |
|--|
| <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Allopurinol   |
| <input type="checkbox"/> Coumadin      |
| <input type="checkbox"/> Dexamethasone |
| <input type="checkbox"/> Emend         |
| <input type="checkbox"/> Granix        |
| <input type="checkbox"/> Jadenu        |
| <input type="checkbox"/> Prednisone    |
| <input type="checkbox"/> Promacta      |
| <input type="checkbox"/> Rasburicase   |
| <input type="checkbox"/> Sancuso       |
| <input type="checkbox"/> Zarxio        |
| <input type="checkbox"/> Zofran        |

### ADJUNCT THERAPY

- |                                       |                                   |
|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Casodex      | <input type="checkbox"/> Trelstar |
| <input type="checkbox"/> Eulexin      | <input type="checkbox"/> Vantas   |
| <input type="checkbox"/> Firmagon     | <input type="checkbox"/> Zoladex  |
| <input type="checkbox"/> Lupron Depot |                                   |
| <input type="checkbox"/> Nilandron    |                                   |

### DOSE/QUANTITY/DIRECTION:

Refill #: \_\_\_\_\_

### PRESCRIBER INFORMATION

Physician's Name (Please Print): \_\_\_\_\_ NPI #: \_\_\_\_\_ License #: \_\_\_\_\_  
 Address, City, State, Zip: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.