TruCare PHARMACY

ONCOLOGY PRESCRIPTION FORM

Phone: (844) 446-0808 | **Fax: (844) 446-0809**

Ship To: ☐ Patient ☐ Physician

Patient Name (Required):		Physician Name:	
Home Phone: ( ) Work Phone: ( )		LIC#:	DEA #:
Cell Phone: ( )		NPI #:	Specialty:
Emergency Contact Name: (Required):		Practice Name/Hospital:	
Emergency Contact Phone #: (Required):		Address:	
Patient Soc. Sec #:	Allergies: ☐ NKA	City: State:	Zip:
DOB (Required):	Sex: ☐ M ☐ F Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:
☐ **See attached demographic sheet**	Height: BSA: m²	Nurse/Key Office Contact:	

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone: ( )	Phone: ( )	Phone: ( )	Group #:

DIAGNOSIS INFORMATION (choose one) | Please FAX clinical notes, Labs, Tests with the prescription

Diagnosis: _____

ICD-10: (required for Medicare B billing) _____ BSA _____ m²

MEDICAL NECESSITY

Renal Dysfunction? ☐ Yes ☐ No Current SCR _____ or current GFR _____ ml/min

Liver Dysfunction? ☐ Yes ☐ No Abnormal Lab Value(s)_____ H/H (Hemoglobin/Hematocrit):_____

Confirmed Mutations: ☐ EGFR ☐ ALK ☐ BRAF V600E ☐ BRAF V600K ☐ CLL with 17p deletion Other:_____

PRESCRIPTION INFORMATION (one month supply will be dispensed unless quantity is indicated)

SOLID TUMORS

☐ **Afinitor®**(everolimus) ☐ **Afinitor®Disperz**(everolimus) ☐ **Arimidex®**(everolimus) ☐ **Erivedge®**(vismodegib)

☐ **Mekinist®**(trametinib) ☐ **Nexavar®**(topotecan) ☐ **Nolvadex®**(sorafenib) ☐ **Stivarga®**(regorafenib)

☐ **Sutent®**(sunitinib malate) ☐ **Sylatron®**(peginterferon alfa-2b) ☐ **Tafinlar®**(dabrafenib) ☐ **Tagrisso™**(osimertinib)

☐ **Tarceva®**(erlotinib) ☐ **Temodar®**(temozolomide) ☐ **Tykerb®**(lapatinib) ☐ **Votrient®**(pazopanib)

☐ **Xalkori®**(crizotinib) ☐ **Xeloda®**(capecitabine) ☐ **Xtandi®**(enzalutamide)

☐ **Zykadia™**(ceritinib) ☐ **Zolinza®**(vorinostat) ☐ _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty:_____ Refills:_____

LIQUID TUMORS

☐ **Bosulif®**(bosutinib) ☐ **Exjade®**(deferasirox) ☐ **Farydak®**(panobinostat) ☐ **Gleevec®**(imatinib mesylate)

☐ **Jadenu™**(deferasirox) ☐ **Jakafi®**(ruxolitinib) ☐ **Sprycel®**(dasatinib) ☐ **Tasigna®**(nilotinib)

☐ **Zydelig™**(idelalisib) ☐ _____

STRENGTH/DIRECTIONS (SIG):

_____ Qty:_____ Refills:_____

☐ **Pomalyst®**(pomalidomide) ☐ **Thalomid®**(thalidomide) ☐ **Revlimid®**(lenalidomide) ☐ **Dexamethasone®**(dexamethasone)

Circle One:

Adult Female - NOT of reproductive potential | Adult Female - NOT of reproductive potential | Male Child

Female Child - NOT of reproductive potential | Adult Female - NOT of reproductive potential | Adult Male

STRENGTH/DIRECTIONS (SIG):

Provider Authorization #:_____ Date:_____ Qty:_____ Refills:_____

☐ **Venclexta™** (venetoclax) Starter Pack Ramp-up dosing: **Week 1**:20mg po QD; **Week 2**: 50mg po QD; **Week 3**: 100mg po QD; **Week 4**: 200mg po QD

Sig: _____

Maintentance: 400mg po qd after completion of ramp-up dosing

Sig: _____

☐ 10mg Wallet Unit dose ☐ 50mg Wallet Unit dose

☐ 100mg Wallet Unit dose Qty:_____ Refills:_____

☐ **Imbruvica™** (ibrutinib)	**Sig:**	**Qty:**	**Refill:**
Waldenström's macroglobulinemia is 420mg (3 capsules) - Mantle Cell Lymphoma is 560mg (4 capsules)-Chronic Lymphocytic Leukemia is 420mg (3 capsules)			
☐ **Lonsurf®** (tipiracil/trifluridine)	☐ 15mg/6.14mg ☐ 20 mg/8.19mg	**Qty:**	**Refill:**
Take _____ mg (35mg/m2 based on trifluridine component) twice daily within 1 hour of completion of morning and evening meals on days 1 through 5 and days 8 through 12 of each 28-day cycle. (round dose to nearest 5mg, max of 80mg/dose)			
☐ **Cotellic™** (cobimetinib)	Sig: Three tablets (60mg) for 21-days on and 7-days off, then repeat		
☐ **Zelboraf®** (vemurafenib)	Sig: Four tablets (960mg) every 12 hours	240 Tab	**Refill:**
☐ **Zytiga®** (abiraterone) ☐ **w/Prednisone**	**Sig:** ☐ 250 mg 4 QD ☐ 5 mg BID w/food	**Qty:**	**Refill:**
☐ **Ibrance®** (palbociclib) ☐ **w/Letrozole**	**Sig:** ☐_____ mg QD w/food for 21 days,then 7 days off ☐ 1 tablet (2.5 mg) QD	21 Tab 28 Tab	**Refill:**
☐ **Ninlaro®** (ixazomib)	One_____mg capsule once weekly on days 1,8, and 15 of a 28-day cycle, 1 hour before or 2 hours after food.	3 Caps	**Refill:**
☐ **Revlimid®** (lenalidomide)	One _____mg capsule for 21 days, then 7-days off, then repeat cycle.	21 Caps	**Provide Auth#:** _____
☐ **Dexamethasone**	40mg (10 tablets) once weekly on days 1,8,15 and 22 of a 28-day cycle.	40 Tab	**Refill:**

SUPPORTIVE MEDICATIONS

☐ **Aranesp®**(everolimus) ☐ **Arixtra®**(everolimus) ☐ **Emend®**(everolimus) ☐ **Granix®**(vismodegib) ☐ **Lovenox®**(trametinib)

☐ **Neulasta®**(topotecan) ☐ **Neupogen®**(sorafenib) ☐ **Nplate®**(regorafenib) ☐ **Procrit®**(sunitinib malate)

☐ **Promacta®**(peginterferon alfa-2b) ☐ **Sancuso®**(dabrafenib) ☐ **Xgeva™**(osimertinib) ☐ **Zarxio®**(osimertinib)

☐ **Zofran®**(idelalisib) ☐ _____

STRENGTH/DIRECTIONS (SIG):

Qty: Refills:

☐ **Allopurinol®** Strength:_____ Qty:_____ Refills:_____

Sig:_____

☐ **DAW** (Dispense as Written) **# of Medications Prescribed:** _____

☐ **OTHER**:

Physician's Signature: _____ **Date:** _____

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescribers are reminded patients may choose any pharmacy of their choice. tcv111816