

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Oral Oncology T Prescription Form

Patient information

Patient: _____ Female Male DOB: _____ Insurance plan: _____ Plan ID #: _____
 Address: _____ City: _____ State: _____ ZIP code: _____
 Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____
 Other medical conditions: _____ Allergies: No Yes: _____

Clinical information

Need by date: _____ BSA: _____ m² Height: _____ Weight: _____ lb kg Date: _____
 ICD-10 code(s): _____ Diagnosis: _____ Diagnosis date: _____
 Renal dysfunction: No Yes Current SCr: _____ or current GFR: _____ mL/min Liver dysfunction: No Yes
 Abnormal lab values: _____ Concurrent Medications: _____
 Confirmed predictive biomarker or genetic testing: No Yes If "Yes," list: _____

Previous therapy:	Discontinuation reason:	Dates:
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

Prescription information Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Tabrecta tablets (capmatinib)	<input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take two tablets twice daily.	_____	_____
<input type="checkbox"/> Tafenlar capsules (dabrafenib) (Please see form "K-M" for Mekinist.)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 75 mg	<input type="checkbox"/> Take two capsules twice daily on an empty stomach.	_____	_____
<input type="checkbox"/> Tagrisso tablets (osimertinib) Check one: <input type="checkbox"/> Metastatic or <input type="checkbox"/> Resectable	<input type="checkbox"/> 40 mg <input type="checkbox"/> 80 mg	<input type="checkbox"/> Take one capsule once daily.	_____	_____
<input type="checkbox"/> Talzenna capsules (talazoparib)	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 1 mg	<input type="checkbox"/> Take one capsule once daily.	_____	_____
<input type="checkbox"/> tamoxifen tablets	<input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg	<input type="checkbox"/> Take one tablet once daily.	_____	_____
<input type="checkbox"/> Targretin capsules (bexarotene)	75 mg	_____	_____	_____
<input type="checkbox"/> Tasiqna capsules (nilotinib)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take two capsules (_____ mg) twice daily on an empty stomach.	_____	_____
<input type="checkbox"/> Temodar capsules (temozolomide)	<input type="checkbox"/> 5 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 140 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 250 mg	_____	_____	_____
<input type="checkbox"/> tretinoin capsules	10 mg	_____	_____	_____
<input type="checkbox"/> Tykerb tablets (lapatinib) (Please see corresponding form for Xeloda or letrozole.)	250 mg	<input type="checkbox"/> Take ___ tablets (_____ mg) once daily on an empty stomach.	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____
 Ship to: Patient Office Other: _____
 Office address: _____ City: _____ State: _____ ZIP code: _____
 Office phone number: _____ Office fax number: _____
 Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.