

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

**Oncology C-E 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: \_\_\_\_\_ m<sup>2</sup> 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"/> Cabometyx tablets (cabozantinib)	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 60 mg	<input type="checkbox"/> Take one tablet once daily on an empty stomach.	_____	_____
<input type="checkbox"/> Cotellic tablets (cobimetinib) (Please see form "Y-Z" for Zelboraf, or write in the "Other" field below.)	20 mg	<input type="checkbox"/> Take three tablets (60 mg) once daily for 21 days. Repeat this cycle every 28 days.	_____	_____
<input type="checkbox"/> cyclophosphamide capsules	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg	_____	_____	_____
<input type="checkbox"/> Daurismo tablets (glasdegib)	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg	<input type="checkbox"/> Take one tablet once daily on days 1 to 28.	_____	_____
<input type="checkbox"/> Emcyt capsules (estramustine)	140 mg	_____	_____	_____
<input type="checkbox"/> Erivedge capsules (vismodegib)	150 mg	<input type="checkbox"/> Take one capsule (150mg) once daily.	_____	_____
<input type="checkbox"/> Erleada tablets (apalutamide)	60 mg	<input type="checkbox"/> Take four tablets (240mg) once daily.	_____	_____
<input type="checkbox"/> erlotinib tablets	<input type="checkbox"/> 25 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg	<input type="checkbox"/> Take one tablet once daily on an empty stomach.	_____	_____
<input type="checkbox"/> etoposide capsules	50 mg	_____	_____	_____
<input type="checkbox"/> everolimus tablets	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 7.5 mg <input type="checkbox"/> 10 mg	<input type="checkbox"/> Take one tablet once daily.	_____	_____
<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.