

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 U–X 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"/> Verzenio tablets (abemaciclib) <input type="checkbox"/> with AI or Faslodex <input type="checkbox"/> without AI or Faslodex (To prescribe AI, please use the corresponding alphabetical form.)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take one tablet twice daily.	_____	_____
<input type="checkbox"/> Vizimpro (dacomitinib)	<input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg	<input type="checkbox"/> Take one tablet once daily.	_____	_____
<input type="checkbox"/> Votrient tablets (pazopanib)	200 mg	<input type="checkbox"/> Take four tablets (800 mg) once daily on an empty stomach.	_____	_____
<input type="checkbox"/> Xalkori capsules (crizotinib)	<input type="checkbox"/> 200 mg <input type="checkbox"/> 250 mg	<input type="checkbox"/> Take one capsule twice daily.	_____	_____
<input type="checkbox"/> Xeloda tablets (capecitabine)	<input type="checkbox"/> 150 mg <input type="checkbox"/> 500 mg	_____	_____	_____
<input type="checkbox"/> Xtandi (enzalutamide)	<input type="checkbox"/> 40 mg capsules <input type="checkbox"/> 40 mg tablets <input type="checkbox"/> 80 mg tablets	<input type="checkbox"/> Take four capsules (160 mg) once daily. <input type="checkbox"/> Take _____ tablets (____ mg) 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.