

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 tablets (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.