



1 PATIENT INFORMATION

Patient's Name _____

Date of Birth _____ Male Female

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Parent/Guardian (if applicable) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Evening Phone _____

E-mail address _____

Insurance Company Name _____

Insurance Company Phone No. _____

Insured's Name _____

Relationship to Patient _____

Identification No. _____ Policy/Group No. _____

Prescription Card No Yes If Yes, Carrier _____

Policy No. _____ Group No. _____

Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____

Office Contact _____

Clinic / Hospital Affiliation _____

Street Address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI No. _____ License No. _____

DEA No. _____

Physician Medicaid UPIN No. _____

MD Specialty _____

3 CLINICAL INFORMATION

ICD9 CODE _____

Current Weight _____ kg _____ lbs Height _____ inches/cm BSA _____ m²

- Rx: **Gleevec**[®] (imatinib mesylate) **Sprycel**[™] (dasatinib)
 Temodar[®] (temozolomide) **Thalomid**[®] (thalidomide)
 Tarceva[™] (erlotinib hydrochloride) Celgene Authorization # _____
 Zolinza[™] (vorinostat) **Sutent**[®] capsules (sunitinib malate)
 Xeloda[®] (capecitabine)

Therapy Specific referral forms required for the following therapies. These forms can be found on our website at www.accredonovafactor.com:**Tykerb**[®] (lapatinib)**Revlimid**[®] (lenalidomide)**Nexavar**[®] (sorafenib)**Exjade**[®] (deferasirox)

Strength(s) _____

SIG: Dose: _____Directions (Include daily, weekly, cyclic, one-time, duration of therapy, etc.)

Quantity: _____ Refills: _____

 NKDA Known Drug Allergies: _____*By signing below, I certify that the above therapy is medically necessary.***Prescriber's Printed Name** _____**Prescriber's Signature (sign below)** _____ **Date** _____**Dispense as Written**(Physician attests this is his/her legal signature. **NO STAMPS**)**Substitution Allowed****EXPECTED DATE OF FIRST/NEXT DOSE:** _____ Date of Last Dose? _____