Oncology
Hematologic Cancer (K-R)
(Ninlaro®, Pomalyst®, Revlimid®, and Rydapt®)

DIPLOMAT®

Diplomat Pharmacy
Phone: 877.977.9118
Fax: 800.550.6272
Insert Sales Contact Name (if known)

Patient information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis (C00-D49): _____ Diagnosis date: _____
Patient Type (if applicable):
☐ Adult female NOT of reproductive potential ☐ Adult female of reproductive potential ☐ Adult male Date: _____
☐ Child female NOT of reproductive potential ☐ Child female of reproductive potential ☐ Child male Authorization: _____
Mutations: ☐ c-Kit ☐ Del 5q ☐ Del 17p ☐ FLT3 ☐ PDGFR ☐ Ph+ ☐ Other Mutation _____
Lymph Node size: _____ cm Absolute Lymphocyte count: _____/L TLS Risk: ☐ Low ☐ Moderate ☐ High Date: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

Prescription		Quantity	Refill
	§ Bosulif®, Farydak®, Gleevec®, Imbruvica®, and Jakafi® are listed alphabetically on respective enrollment forms§		
☐ **Ninlaro® (ixazomib)**	☐ Take 4 mg once weekly by mouth on days 1, 8, and 15 of a 28-day cycle ☐ _____	☐ 3 x 4 mg capsules ☐ _____	_____
☐ **Pomalyst® (pomalidomide)**	☐ Take 4 mg once daily by mouth on days 1-21 of a 28-day cycle ☐ _____	☐ 21 x 4 mg capsules ☐ _____	0
☐ **Dexamethasone**	☐ Take 40 mg once daily by mouth with food on days 1, 8, 15, and 22 of a 28-day cycle ☐ _____	☐ 4 x 40 mg capsules ☐ _____	_____
☐ **Aspirin**	☐ Take 81 mg once daily by mouth ☐ _____	☐ 28 x 81 mg tablets ☐ _____	_____
	☐ **Check here to dispense Pomalyst® with dexamethasone and/or aspirin in a CarePak™.** *CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule.*		
☐ **Revlimid® (lenalidomide)**	☐ Take 10 mg once daily by mouth ☐ Take 25 mg once daily by mouth on days 1-21 of a 28-day cycle ☐ _____	☐ 28 x 10 mg capsules ☐ 21 x 25 mg capsules ☐ _____	0
☐ **Dexamethasone**	☐ Take 40 mg once daily by mouth with food on days 1, 8, 15 and 22 of a 28-day cycle ☐ _____	☐ 4 x 40 mg capsules ☐ _____	_____
☐ **Aspirin**	☐ Take 81 mg once daily by mouth ☐ _____	☐ 28 x 81 mg tablets ☐ _____	_____
	☐ **Check here to dispense Revlimid® with dexamethasone and/or aspirin in a CarePak™.** *CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule.*		
☐ **Rydapt® (midostaurin)**	☐ Take 50 mg twice daily by mouth with food on days 8-21 of each cycle ☐ Take 100 mg twice daily by mouth with food ☐ _____	☐ 56 x 25 mg capsules ☐ 224 x 25 mg capsules ☐ _____	_____
	§Sprycel®, Synribo®, Tasigna®, Thalomid®, Venclexta™, Zolinza®, and Zydelig® are listed alphabetically on respective enrollment forms§		

For patients requiring immune globulin therapy, please fill out respective form: IVIg or SCIg.
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

Reset Form