

Oncology Hematologic Cancer (K-R)

(Ninlaro®, Pomalyst®, Revlimid®, and Rydapt®)



Patient information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis (C00-D49): _____		Diagnosis date: _____	
Patient Type (if applicable):			
<input type="checkbox"/> Adult female NOT of reproductive potential	<input type="checkbox"/> Adult female of reproductive potential	<input type="checkbox"/> Adult male	Date: _____
<input type="checkbox"/> Child female NOT of reproductive potential	<input type="checkbox"/> Child female of reproductive potential	<input type="checkbox"/> Child male	Authorization: _____
Mutations: <input type="checkbox"/> c-Kit <input type="checkbox"/> Del 5q <input type="checkbox"/> Del 17p <input type="checkbox"/> FLT3 <input type="checkbox"/> PDGFR <input type="checkbox"/> Ph+ <input type="checkbox"/> Other Mutation _____			
Lymph Node size: _____ cm Absolute Lymphocyte count: _____/L TLS Risk: <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High Date: _____			
Prior Therapy	Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
§ Bosulif®, Farydak®, Gleevec®, Imbruvica®, and Jakafi® are listed alphabetically on respective enrollment forms§		
<input type="checkbox"/> Ninlaro® (ixazomib)	<input type="checkbox"/> Take 4 mg once weekly by mouth on days 1, 8, and 15 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 3 x 4 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Pomalyst® (pomalidomide)	<input type="checkbox"/> Take 4 mg once daily by mouth on days 1-21 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 21 x 4 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Take 40 mg once daily by mouth with food on days 1, 8, 15, and 22 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 4 x 40 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Take 81 mg once daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 81 mg tablets <input type="checkbox"/> _____
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.		
<input type="checkbox"/> Revlimid® (lenalidomide)	<input type="checkbox"/> Take 10 mg once daily by mouth <input type="checkbox"/> Take 25 mg once daily by mouth on days 1-21 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 10 mg capsules <input type="checkbox"/> 21 x 25 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Take 40 mg once daily by mouth with food on days 1, 8, 15 and 22 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 4 x 40 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Take 81 mg once daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 81 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> 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.		
<input type="checkbox"/> 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 _____

§Spryce®, 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.

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