

Oncology Hematologic Cancer (S-T)

(Sprycel®, Synribo®, Tasigna®, and Thalomid®)



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"/> Child female NOT of reproductive potential		<input type="checkbox"/> Child female of reproductive potential	
		<input type="checkbox"/> Adult male Date: _____	
		<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®, Jakafi®, Ninlaro®, Pomalyst®, Revlimid® and Rydapt® are listed alphabetically on respective enrollment forms§		
<input type="checkbox"/> Sprycel® (dasatinib)	<input type="checkbox"/> Take 100 mg once daily by mouth <input type="checkbox"/> Take 140 mg once daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 30 x 100 mg tablets <input type="checkbox"/> 30 x 140 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> Synribo® (omacetaxine mepesuccinate)	To order Synribo® please see the Teva form at http://www.synribohcp.com/pdf/Request_Form.PDF Phone: 844-796-2273 Fax: 855-796-7426	
<input type="checkbox"/> Tasigna® (nilotinib)	<input type="checkbox"/> Take 300 mg twice daily (every 12 hours) by mouth on an empty stomach <input type="checkbox"/> Take 400 mg twice daily (every 12 hours) by mouth on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 112 x 150 mg capsules <input type="checkbox"/> 112 x 200 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Thalomid® (thalidomide)	<input type="checkbox"/> Take 200 mg once daily by mouth with water, preferably at bedtime and at least 1 hour after the evening meal <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 200 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Take 40 mg once daily by mouth with food on days 1-4, 9-12 and 17-20 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 12 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"/> _____
§ Venclexta™, Zolanza® and Zydelig® are listed alphabetically on respective enrollment forms§		
For patients requiring immune globulin therapy, please fill out the respective form: IVlg or SClg .		
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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