Oncology

Other Cancers (drugs A-S)

(Afinitor®, Afinitor® Disperz, Cometriq®, Gleevec®, Nexavar®, Stivarga®, Sutent®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: ☐ Female ☐ Male SSN: _____	NPI: _____
Language: _____ Wt: _____ ☐ kg ☐ lbs Ht: _____ ☐ cm ☐ in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: ☐ First Fill ☐ Always ☐ 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: _____

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

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription		Quantity	Refill
☐ **Afinitor® (everolimus)**	☐ Take 10 mg by mouth once daily with a full glass of water ☐ _____	☐ 28 x 10 mg tablets ☐ _____	_____
☐ **Cometriq® (cabozantinib)**	☐ Take 140 mg (one 80 mg and three 20 mg) by mouth once daily on an empty stomach ☐ _____	☐ 28 x 80 mg capsules 84 x 20 mg capsules ☐ _____	_____
☐ **Gleevec® (imatinib)**	☐ Take 400 mg by mouth once daily with a meal and full glass of water ☐ Take 600 mg by mouth once daily bwith a meal and full glass of water ☐ Take _____ mg (340 mg/m²/day x _____ m²) by mouth once daily with a meal and full glass of water ☐ _____	☐ 30 x 400 mg tablets ☐ 30 x 400 mg tablets 60 x 100 mg tablets ☐ _____	_____
☐ **Nexavar® (sorafenib)**	☐ Take 400 mg by mouth twice daily on an empty stomach ☐ _____	☐ 120 x 200 mg tablets ☐ _____	_____
☐ **Stivarga® (regorafenib)**	☐ Take 160 mg by mouth once daily with a low-fat meal on days 1-21 of a 28-day cycle ☐ _____	☐ 84 x 40 mg tablets ☐ _____	_____
☐ **Sutent® (sunitinib)**	☐ Take 50 mg by mouth once daily on days 1-28 of a 42-day cycle ☐ Take 37.5 mg by mouth once daily ☐ _____	☐ 28 x 50 mg capsules ☐ 28 x 37.5 mg capsules ☐ _____	_____

§ Tafinlar® + Mekinist®, Tarceva®, Temodar®, Votrient®, Xeloda® and Zejula™ are listed alphabetically on respective enrollment forms§

For patients requiring immune globulin therapy, please fill out the 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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