

# Oncology



## Other Cancers (drugs A-S)

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

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: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	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

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis (C00-D49): _____		Diagnosis date: _____	
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	Reason for Discontinuation of Therapy _____ _____	Approximate Start Date _____ _____	Approximate End Date _____ _____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
<input type="checkbox"/> <b>Afinitor®</b> (everolimus)	<input type="checkbox"/> Take 10 mg by mouth once daily with a full glass of water <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 10 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> <b>Cometriq®</b> (cabozantinib)	<input type="checkbox"/> Take 140 mg (one 80 mg and three 20 mg) by mouth once daily on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 80 mg capsules <input type="checkbox"/> 84 x 20 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> <b>Gleevec®</b> (imatinib)	<input type="checkbox"/> Take 400 mg by mouth once daily with a meal and full glass of water <input type="checkbox"/> Take 600 mg by mouth once daily bwith a meal and full glass of water <input type="checkbox"/> Take _____ mg (340 mg/m <sup>2</sup> /day x _____ m <sup>2</sup> ) by mouth once daily with a meal and full glass of water <input type="checkbox"/> _____	<input type="checkbox"/> 30 x 400 mg tablets <input type="checkbox"/> 30 x 400 mg tablets <input type="checkbox"/> 60 x 100 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> <b>Nexavar®</b> (sorafenib)	<input type="checkbox"/> Take 400 mg by mouth twice daily on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 120 x 200 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> <b>Stivarga®</b> (regorafenib)	<input type="checkbox"/> Take 160 mg by mouth once daily with a low-fat meal on days 1-21 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 84 x 40 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> <b>Sutent®</b> (sunitinib)	<input type="checkbox"/> Take 50 mg by mouth once daily on days 1-28 of a 42-day cycle <input type="checkbox"/> Take 37.5 mg by mouth once daily <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 50 mg capsules <input type="checkbox"/> 28 x 37.5 mg capsules <input type="checkbox"/> _____

§ 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: [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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