

Oncology

Hematologic Cancer (drugs Ti-Z)

(Tibsovo®, Venclexta™, Zelboraf®, Zolinza®, and Zydelig®)



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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: <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-E88): _____		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"/> BRAF V600 <input type="checkbox"/> IDH1		Other: _____	
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®, Calquence®, Copiktra™, Farydak®, Gleevec®, IDHIFA®, Imbruvica®, Jakafi®, Ninlaro®, Pomalyst®, Revlimid®, Rydapt®, Sprycel®, Synribo®, Tasigna® and Thalomid® are listed alphabetically on respective enrollment forms§		
Tibsovo® (ivosidenib)	Take 500 mg by mouth once daily	60 x 250 mg tablets
Venclexta™ (venetoclax)	<input type="checkbox"/> Take 20 mg once daily during week 1, 50 mg once daily during week 2, 100 mg once daily during week 3, 200 mg once daily during week 4 by mouth with food and water	<input type="checkbox"/> 1 starter pack
	<input type="checkbox"/> Take 400 mg by mouth once daily with food and water	<input type="checkbox"/> 120 x 100 mg tablets
	Patient will be obtaining either Allopurinol or Rasburicase at: <input type="checkbox"/> Diplomat (fill prescription below) <input type="checkbox"/> Other pharmacy <input type="checkbox"/> Not receiving (Reason: _____)	
<input type="checkbox"/> Allopurinol		
<input type="checkbox"/> Rasburicase		
Zelboraf® (vemurafenib)	Take 960 mg by mouth twice daily (every 12 hours)	240 x 240 mg tablets
Zolinza® (vorinostat)	Take 400 mg by mouth once daily with food	<input type="checkbox"/> 120 x 100 mg capsules
Zydelig® (idelalisib)	Take 150 mg by mouth twice daily	<input type="checkbox"/> 60 x 150 mg tablets

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: _____

Stamp signature not allowed, physician signature required.

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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