Oncology

Hematologic Cancer (drugs Ti-Z)

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

DIPLOMAT®

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

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis (C00-E88): _____ Diagnosis date: _____
Patient Type (if applicable): _____
☐ Adult female NOT of reproductive potential ☐ Adult female of reproductive potential ☐ Adult male Date: _____
☐ Child female NOT of reproductive potential ☐ Child female of reproductive potential ☐ Child male Authorization: _____
Mutations: ☐ c-Kit ☐ Del 5q ☐ Del 17p ☐ FLT3 ☐ PDGFR ☐ Ph+ ☐ BRAF V600 ☐ IDH1 ☐ Other: _____
Lymph Node size: _____ cm Absolute Lymphocyte count: _____/L TLS Risk: ☐ Low ☐ Moderate ☐ High Date: _____

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

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other:

Prescription

§ Bosulif®, Calquence®, Copiktra™, Farydak®, Gleevec®, IDHIFA®, Imbruvica®, Jakafi®, Ninlaro®, Pomalyst®, Revlimid®, Rydapt®, Sprycel®, Synribo®, Tasigna® and Thalomid® are listed alphabetically on respective enrollment forms§

		Quantity	Refill
☐ **Tibsovo® (ivosidenib)**	☐ Take 500 mg by mouth once daily ☐ _____	☐ 60 x 250 mg tablets ☐ _____	_____
☐ **Venclexta™ (venetoclax)**	☐ 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	☐ 1 starter pack	0
	☐ Take 400 mg by mouth once daily with food and water ☐ _____	☐ 120 x 100 mg tablets ☐ _____	_____
	Patient will be obtaining either Allopurinol or Rasburicase at: ☐ Diplomat (fill prescription below) ☐ Other pharmacy ☐ Not receiving (Reason: _____)		
☐ **Allopurinol**			
☐ **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 ☐ _____	☐ 120 x 100 mg capsules ☐ _____	_____
☐ **Zydelig® (idelalisib)**	☐ Take 150 mg by mouth twice daily ☐ _____	☐ 60 x 150 mg tablets ☐ _____	_____

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: _____

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.

Reset Form