# Oncology

## Other Cancers (S-Z)

**(Stivarga®, Sutent®, Tarceva®, Temodar®, Votrient®, Xeloda®)**

| 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: ______

Mutations: ❑ EGFR ❑ ______

| 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®, Afinitor® Disperz, Cometriq®, Gleevec®, Lonsurf® and Nexavar® are listed alphabetically on respective enrollment forms§ | | | |
| ❑ **Stivarga®** **(regorafenib)** | ❑ Take 160 mg once daily by mouth with a low-fat meal on days 1-21 of a 28-day cycle<br>❑ ______ | ❑ 84 x 40 mg tablets<br>❑ ______ | ______ |
| ❑ **Sutent®** **(sunitinib)** | ❑ Take 50 mg once daily by mouth on days 1-28 of a 42-day cycle<br>❑ Take 37.5 mg once daily by mouth<br>❑ ______ | ❑ 28 x 50 mg capsules<br>❑ 28 x 37.5 mg capsules<br>❑ ______ | ______ |
| ❑ **Tarceva®** **(erlotinib)** | ❑ Take 150 mg once daily by mouth on an empty stomach<br>❑ Take 100 mg once daily by mouth on an empty stomach<br>❑ Take ______ mg once daily by mouth on an empty stomach | ❑ 30 x 150 mg tablets<br>❑ 30 x 100 mg tablets<br>❑ ______ | ______ |
| ❑ **Temodar®** **(temozolomide)** | ❑ Take ______ mg (75 mg/m²/day x ______ m²) once daily by mouth on an empty stomach with a full glass of water on days ______ of a ______-day cycle<br>❑ Take ______ mg (150 mg/m²/day x ______ m²) once daily by mouth on an empty stomach with a full glass of water on days 1-5 of a 28-day cycle<br>❑ ______ | ❑ ______ | ______ |
| ❑ **Votrient®** **(pazopanib)** | ❑ Take 800 mg once daily by mouth on an empty stomach<br>❑ ______ | ❑ 120 x 200 mg tablets<br>❑ ______ | ______ |
| ❑ **Xeloda®** **(capecitabine)** | ❑ Take ______ mg (1250 mg/m²/dose x ______ m²) twice daily (every 12 hours) by mouth within 30 minutes after a meal on days 1-14 of a 21-day cycle<br>❑ ______ | ❑ ______ x 150 mg tablets<br>______ x 500 mg tablets<br>❑ ______ | ______ |

For patients requiring immune globulin therapy, please fill out 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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