Oncology

Hematologic Cancer (T-Z)

(Tasigna®, Thalomid®, Venclexta™, Zolinza®, Zydelig®)

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: _____

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: ☐ V600E ☐ V600K ☐ EGFR ☐ ALK ☐ KRAS ☐ ROS1 ☐ 17p deletion ☐ _____

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		Quantity	Refill
§ Bosulif®, Farydak®, Gleevec®, Imbruvica®, Jakafi®, Ninlaro®, Pomalyst®, Revlimid®, Sprycel®, and Synribo® are listed alphabetically on respective enrollment forms§			
☐ **Tasigna® (nilotinib)**	☐ Take 300 mg twice daily (every 12 hours) by mouth on an empty stomach ☐ Take 400 mg twice daily (every 12 hours) by mouth on an empty stomach ☐ _____	☐ 112 x 150 mg capsules ☐ 112 x 200 mg capsules ☐ _____	_____
☐ **Thalomid® (thalidomide)**	☐ Take 200 mg once daily by mouth with water, preferably at bedtime and at least 1 hour after the evening meal ☐ _____	☐ 28 x 200 mg capsules ☐ _____	0
☐ **Dexamethasone**	☐ Take 40 mg once daily by mouth with food on days 1-4, 9-12 and 17-20 of a 28-day cycle ☐ _____	☐ 12 x 40 mg capsules ☐ _____	_____
☐ **Aspirin**	☐ Take 81 mg once daily by mouth ☐ _____	☐ 28 x 81 mg tablets ☐ _____	_____
☐ **Venclexta™ (venetoclax)**	☐ Take one tablet once daily by mouth with food and water Take 20 mg during week 1, 50 mg during week 2, 100 mg during week 3, and 200 mg during week 4. ☐ _____	☐ 1 starter pack ☐ _____	0
	☐ Take 400 mg once daily by mouth with food and water ☐ _____	☐ 120 x 100 mg tablets ☐ _____	_____
☐ **Allopurinol**			
☐ **Rasburicase**			
☐ **Zolinza® (vorinostat)**	☐ Take 400 mg once daily by mouth with food ☐ _____	☐ 120 x 100 mg capsules ☐ _____	_____
☐ **Zydelig® (idelalisib)**	☐ Take 150 mg twice daily by mouth ☐ _____	☐ 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: _____

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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