

Oncology

Hematologic Cancer (T-Z)

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



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: _____

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

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 <input type="checkbox"/> Yes <input type="checkbox"/> 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§

<input type="checkbox"/> Tasigna® (nilotinib)	<input type="checkbox"/> Take 300 mg twice daily (every 12 hours) by mouth on an empty stomach <input type="checkbox"/> Take 400 mg twice daily (every 12 hours) by mouth on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 112 x 150 mg capsules <input type="checkbox"/> 112 x 200 mg capsules <input type="checkbox"/> _____	_____
<input type="checkbox"/> Thalomid® (thalidomide)	<input type="checkbox"/> Take 200 mg once daily by mouth with water, preferably at bedtime and at least 1 hour after the evening meal <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 200 mg capsules <input type="checkbox"/> _____	0
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Take 40 mg once daily by mouth with food on days 1-4, 9-12 and 17-20 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 12 x 40 mg capsules <input type="checkbox"/> _____	_____
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Take 81 mg once daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 81 mg tablets <input type="checkbox"/> _____	_____
<input type="checkbox"/> Venclexta™ (venetoclax)	<input type="checkbox"/> 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. <input type="checkbox"/> _____	<input type="checkbox"/> 1 starter pack <input type="checkbox"/> _____	0
	<input type="checkbox"/> Take 400 mg once daily by mouth with food and water <input type="checkbox"/> _____	<input type="checkbox"/> 120 x 100 mg tablets <input type="checkbox"/> _____	_____
<input type="checkbox"/> Allopurinol			
<input type="checkbox"/> Rasburicase			
<input type="checkbox"/> Zolinza® (vorinostat)	<input type="checkbox"/> Take 400 mg once daily by mouth with food <input type="checkbox"/> _____	<input type="checkbox"/> 120 x 100 mg capsules <input type="checkbox"/> _____	_____
<input type="checkbox"/> Zydelig® (idelalisib)	<input type="checkbox"/> Take 150 mg twice daily by mouth <input type="checkbox"/> _____	<input type="checkbox"/> 60 x 150 mg tablets <input type="checkbox"/> _____	_____

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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