Oncology
Hematologic Cancer (K-S)
(Ninlaro®, Pomalyst®, Revlimid®, Sprycel®, Synribo®)

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®, and Jakafi® are listed alphabetically on respective enrollment forms§		
❑ **Ninlaro® (ixazomib)**	❑ Take 4 mg once weekly by mouth on days 1, 8, and 15 of a 28-day cycle ❑ ____	❑ 3 x 4 mg capsules ❑ ____	____
❑ **Pomalyst® (pomalidomide)**	❑ Take 4 mg once daily by mouth on days 1-21 of a 28-day cycle ❑ ____	❑ 21 x 4 mg capsules ❑ ____	0
❑ **Dexamethasone**	❑ Take 40 mg once daily by mouth with food on days 1, 8, 15, and 22 of a 28-day cycle ❑ ____	❑ 4 x 40 mg capsules ❑ ____	____
❑ **Aspirin**	❑ Take 81 mg once daily by mouth ❑ ____	❑ 28 x 81 mg tablets ❑ ____	____
Check here to dispense Pomalyst® with dexamethasone and/or aspirin in a CarePak™. *CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule.*			
❑ **Revlimid® (lenalidomide)**	❑ Take 10 mg once daily by mouth ❑ Take 25 mg once daily by mouth on days 1-21 of a 28-day cycle ❑ ____	❑ 28 x 10 mg capsules ❑ 21 x 25 mg capsules ❑ ____	0
❑ **Dexamethasone**	❑ Take 40 mg once daily by mouth with food on days 1, 8, 15 and 22 of a 28-day cycle ❑ ____	❑ 4 x 40 mg capsules ❑ ____	____
❑ **Aspirin**	❑ Take 81 mg once daily by mouth ❑ ____	❑ 28 x 81 mg tablets ❑ ____	____
❑ **Check here to dispense Revlimid® with dexamethasone and/or aspirin in a CarePak .** *CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule.*			
❑ **Sprycel® (dasatinib)**	❑ Take 100 mg once daily by mouth ❑ Take 140 mg once daily by mouth ❑ ____	❑ 30 x 100 mg tablets ❑ 30 x 140 mg tablets ❑ ____	____
Synribo® (omacetaxine mepesuccinate)	To order Synribo® please see the Teva form at http://www.synribohcp.com/pdf/Request_Form.PDF Phone: 844-796-2273 Fax: 855-796-7426		
	§Tasigna®, Thalomid®, Venclexta™, Zolinza®, and Zydelig® are listed alphabetically on respective enrollment forms§		

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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