# Oncology

## Other Cancers (S-Z)

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

## 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-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

§ Afinitor®, Afinitor® Disperz, Cometriq®, Gleevec®, Lonsurf® and Nexavar® are listed alphabetically on respective enrollment forms§

| Prescription | | Quantity | Refill |
|---|---|---|---|
| ❑ **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>❑ ____________ | _____ |
| **Zejula™** **(niraparib)** | Take 300 mg once daily by mouth<br>❑ ______________________ | 90 x 100 mg capsules<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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