ORAL ONCOLOGY

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE
Where Caring Matters

PATIENT INFORMATION

Last Name:
First Name:
SSN#: DOB:
Guardian/Caregiver:
Phone (H): Phone (W/M):
Home Address:
City/State/Zip:
Email:

INSURANCE

**Complete and Fax Copy of Card*

Medical Insurance*: Phone:
Subscriber Name:
Policy #: Group #:
Prescription Card*: Phone:
Policy #: BIN/PCN:
Medicare #: Medicaid #:
City/State/Zip:
Email:

PHYSICIAN

☐ MD ☐ DO ☐ NP ☐ PA
Prescriber Name:
Prescriber Address:
City/State/Zip:
Practice Name:
Phone: Fax:
License #: NPI #: UPIN #:
DEA:
Supervising Physician (if applicable):
Office Contact:
Backline Phone Number:

PRESCRIPTION

☐ AFINITOR (everolimus) tabs Dispense: _____ Refills: _____
☐ 2.5mg ☐ 5mg ☐ 7.5mg ☐ 10mg
☐ Sig:_____

☐ AFINITOR DISPERZ tabs Dispense: _____ Refills: _____
(everolimus tabs for oral suspension)
☐ 2.5mg ☐ 3mg ☐ 5mg ☐ Sig:_____

☐ BOSULIF (bosutinib) tabs Dispense: _____ Refills: _____
☐ 100mg ☐ 500mg ☐ Sig:_____

☐ ERIVEDGE (vismodegib) 150mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ GLEEVEC (imatinib) tabs Dispense: _____ Refills: _____
☐ 100mg ☐ 400mg ☐ Sig:_____

☐ ICLUSIG (ponatinib) tabs Dispense: _____ Refills: _____
☐ 15mg ☐ 45mg ☐ Sig: taken 45mg qd po with or without food
Sig: _____

☐ INLYTA (axitinib) tabs Dispense: Refills: _____
☐ 1mg ☐ 5mg ☐ Sig:_____

☐ INTRON A (interferon alfa 2b) tabs Dispense: _____ Refills: _____
☐ Multi-Dose Pens ☐ Powder for Injection (vials) ☐ Sig:_____

☐ JAKAFI tabs Dispense: _____ Refills: _____
☐ 5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg
Sig:_____

☐ LUPRON (leuprolide) injection Dispense: Refills: _____
☐ Sig:_____

☐ NEXAVAR (sorafenib) 200mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ REVLIMID (lenalidomide) tabs Dispense: Refills: _____
☐ Sig:_____ (Please complete only the Revlimid Patient Prescription Form)

☐ NEULASTA Sig: _____ #: _____ Refills: _____
☐ NEUPOGEN Sig: _____ #: _____ Refills: _____
☐ PROCRIT Sig: _____ #: _____ Refills: _____
☐ ARANESP Sig: _____ #: _____ Refills: _____
☐ ANZEMET Sig: _____ #: _____ Refills: _____
☐ EMEND Sig: _____ #: _____ Refills: _____
☐ KYTRIL Sig: _____ #: _____ Refills: _____
☐ ZOFRAN Sig: _____ #: _____ Refills: _____
☐ ARIXTRA Sig: _____ #: _____ Refills: _____

☐ SPRYCEL (dasatinib) tabs Dispense: _____ Refills: _____
☐ 20mg ☐ 50mg ☐ 70mg ☐ 100mg
☐ Sig:_____

☐ STIVARGA (regorafenib) 40mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ SUTENT (sunitinib) caps Dispense: _____ Refills: _____
☐ 12.5mg ☐ 25mg ☐ 50mg ☐ Sig:_____

☐ TARCEVA (vismodegib) Dispense: _____ Refills: _____
☐ 25mg ☐ 100mg ☐ 150mg ☐ Sig:_____

☐ TASIGNA (nilotinib) caps Dispense: _____ Refills: _____
☐ 150mg ☐ 200mg ☐ Sig:_____

☐ TEMODAR (temozolomide) caps Dispense: _____ Refills: _____
☐ 5mg ☐ 20mg ☐ 100mg ☐ 140mg ☐ 180mg ☐ 250mg
☐ Unit Dose Packaging
☐ Sig: _____

☐ THALOMID (thalidomide) caps Dispense: _____ Refills: _____
☐ 50mg ☐ 100mg ☐ 150mg ☐ 200mg Auth #:_____
☐ Sig:_____

☐ TYKERB (lapatinib) 250mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ VOTRIENT (pazopanib) 200mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ XALKORI (crizotinib) tabs Dispense: _____ Refills: _____
☐ 200mg ☐ 250mg ☐ Sig:_____

☐ XELODA (capecitabine) tabs Dispense: _____ Refills: _____
☐ 150mg ☐ 500mg ☐ Unit Dose Packaging
☐ Sig:_____

☐ XTANDI (enzalutamide) 40mg caps Dispense: _____ Refills: _____
☐ Sig:_____

☐ ZELBORAF (vemurafenib) 240mg tabs Dispense: _____ Refills: _____
☐ Sig:_____

☐ ZYTIGA (abiraterone acetate) 250mg tabs Dispense: _____ Refills: _____
☐ Sig:_____
☐ Prednisone Dispense: _____ Refills: _____
☐ 5mg ☐ 20mg ☐ 100mg ☐ 140mg
☐ Sig:_____ ☐ Unit Dose Packaging

☐ OTHER Dispense: _____ Refills: _____
☐ Sig:_____

CLINICAL INFORMATION

Please include copies of any clinical information (lab results, H&P, etc.) that are relevant to the therapy you are ordering.

Patient Weight: _____ kg lbs (circle one) Allergies:_____

☐ Renal Cell Carcinoma (189.0)
☐ Breast Cancer (174.0)
☐ Prostate Cancer (185.0)
☐ Chronic Myeloid Leukemia (205.1)
☐ Acute Lymphoid Leukemia (204.0)
☐ GIST (151.0)
☐ Liver Cancer (155.0)
☐ Multiple Myeloma (203.0)
☐ Myelodysplastic Syndrome (238.75)
☐ Lung Cancer (162.0)
☐ Pancreatic Cancer (157.0)
☐ Brain Cancer (191.0)
☐ Colon Cancer (153.0)
☐ Other:_____

Meds Tried & Failed (Include drug name and date of therapy): _____

NURSING

Nursing: ☐ Provide nurse for patient injection training or infusion of medication as ordered

Deliver to: ☐ Patient's Home
☐ Prescriber
☐ Other:_____

Prescriber Signature Date

☐ Hold Shipment until notified by prescriber

No Stamps, Prescriber Signature Required
NY Prescriptions must be submitted on NY State Rx Form