CIENEGA PHARMACY

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Oral Oncology Prescription Form

DATE:_____ NEEDS BY DATE:_____ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER _____

PATIENT INFO

Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	❑ Male ❑ Female

PRESCRIBER INFO

Prescriber Name		
DEA#	NPI#	License#
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑153-154 Metastatic Colorectal Cancer ❑205.1 Chronic Myeloid Leukemia ❑189 Renal Cell Carcinoma ❑202.1 Cutaneous T-Cell Lymphoma (Mycosis Fungoides)
❑202.2 Cutaneous T-Cell Lymphoma (Sezary's Disease) ❑152.9 Gastrointestinal Stromal Tumors ❑162.9 Pulmonary Malignancy ❑157.9 Adenocarcinoma of Pancreas
❑203 Multiple Myeloma ❑191.9 Glioblastoma ❑695.2 Erythema Nodosum (ENL) ❑155.0 Hepatocellular Carcinoma ❑ 174._____ Breast Cancer ❑ Other _____

MEDICAL ASSESSMENT

- Has patient been treated previously for this condition? ❑Yes ❑No (If pt has been on Xeloda, please indicate dose and duration of therapy) Medications: _____
- Cancer Stage: ❑Stage 0 ❑Stage I ❑Stage II ❑Stage III ❑Stage IV ❑Other _____
- Is patient currently on therapy? ❑Yes ❑No Medications_:_____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes, what is the washout period? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax m:edication profile)_____

❑ **AFINITOR** ❑ 2.5 mg tab ❑ 5 mg tab ❑ 7.5 mg tab ❑ 10 mg tab

❑ **BOSULIF** ❑ 100 mg tab ❑ 500 mg tab

❑ **CAPECITABINE** *1250 mg/m² po BID for 14 days followed by 7 days of rest (2 weeks on, 1 week off)*
Please indicate number of tablets to be taken at each dose:
Dosage: (___of 500 mg &__ of 150 mg tabs) QAM & (____of 500 mg &__ of 150 mg tabs) QPM for ___days followed by__days of rest.

❑ **GLEEVEC** ❑ 100 mg tab ❑ 400 mg tab (will dispense combination of 100 mg and 400 mg tab based on patient's dose)

❑ **HYCAMTIN** ❑ 0.25 mg tab ❑ 1 mg tab

❑ **INLYTA** ❑ 1 mg tab ❑ 5 mg tab (will dispense combination of 1 mg and 5 mg tab based on patient's dose)

❑ **MEKINIST** ❑ 0.5 mg tab ❑ 1 mg tab ❑ 2 mg tab

❑ **PROMACTA** ❑ 12.5 mg tab ❑ 25 mg tab ❑ 50 mg tab ❑ 75 mg tab ❑ 100 mg tab

❑ **SPRYCEL** ❑ 20 mg tab ❑ 50 mg tab ❑ 70 mg tab ❑ 80 mg tab ❑ 100 mg tab ❑ 140 mg tab

❑ **SUTENT** ❑ 12.5 mg cap ❑ 25 mg cap ❑ 50 mg cap ❑ 50mg po daily for 4 wks on and 2 wks off

❑ **TAFINLAR** ❑ 50 mg cap ❑ 75 mg cap

❑ **TARCEVA** ❑ 25 mg tab ❑ 100 mg tab ❑ 150 mg tab

❑ **TASIGNA** ❑ 150 mg cap ❑ 200 mg cap

❑ **TEMOZOLOMIDE** ❑ 5 mg cap ❑ 20 mg cap ❑ 100 mg cap ❑ 140 mg cap ❑ 180 mg cap ❑ 250 mg cap
Total daily dose based on BSA:_____mg po daily for_____days on and_____days off, repeat cycle every_____days for_____cycles

❑ **THALOMID** ❑ 50mg cap ❑ 100 mg cap ❑ 150 mg cap ❑ 200 mg cap

❑ **TYKERB** ❑ 250 mg tab

❑ **VOTRIENT** ❑ 200mg tab

❑ **XTANDI** ❑ 40 mg cap ❑ 160 mg (four 40 mg caps) po daily ❑ Alt. dosage_:_____

❑ **ZYTIGA** ❑ 250mg tab; 4 tabs daily (1000mg) ❑ In combination with Prednisone 5mg tab BID ❑ Alt. Dosage_:_____

❑ **OTHER**_____ Qty: _____ Refills: _____
Dosage:_____ Qty: _____ Refills: _____
Dosage:_____ Qty: _____ Refills:_____

❑ **ANTIEMETICS:** ❑Chemo-induced N/V ❑Radiation-induced N/V
❑**PROCHLORPERAZINE** ❑**Emend** ❑**ONDANSETRON** ❑**DOLASETRON** ❑**GRANISETRON** ❑**ALOXI** ❑**Other**_____
Dosage: _____ Qty:_____ Refills:_____

❑ **SUPPORTIVE AGENTS:**
❑ **NEUPOGEN** ❑ **NEULASTA** ❑ **PROCRIT** ❑ **EPOGEN** ❑ **ARANESP**
Dosage:_____ Qty:_____ Refills:_____

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

_____ _____ _____
Prescriber's Signature (no stamps) Date If Brand required check ❑ DAW