meijer specialty pharmacy

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IV - Oncology (I-Z)

Ixempra®, Jevtana®, Keytruda®, Opdivo®, Perjeta®, Polivy™, Rituxan®, Torisel®, Velcade®, Vidaza®, Yervoy®, Zaltrap®, Zoledronic Acid

Prescriber Information

Ship Meds to: ◯ Patient's Home ◯ Prescriber's Office

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Collaborating Physician:	
Address:		City:	
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10 Code:	Weight ______ ◯lb / ◯kg Height ________ ◯in / ◯cm	BSA _______ m2	Diagnosis Date: / /
Current SCr ______________ or current GFR ____________ ml/min	Confirmed Mutations:		
Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Prescription Information

Medication	Dose/Strength	Sig (Please Include Cycle)	Quantity	Refills
◯ **IXEMPRA®** (ixabepilone)	◯ 15mg vial ◯ 45mg vial			
◯ **JEVTANA®** (cabazitaxel)	◯ 60mg vial			
◯ **KEYTRUDA®** (pembrolizumab)	◯ 100mg/4mL vial			
◯ **OPDIVO®** (nivolumab)	◯ 40mg vial ◯ 100mg vial ◯ 240mg vial			
◯ **PERJETA®** (pertuzumab)	◯ 420mg vial			
◯ **POLIVY™** (polatuzumab vedotin-piiq)	◯ 140mg vial			
◯ **RITUXAN®** (rituximab) Biosimilar: ◯ Ruxience®	◯ 100mg/10mL vial ◯ 500mg/50mL vial			
◯ **TORISEL®** (temsirolimus)	◯ 25mg/mL vial			
◯ **VELCADE®** (bortezomib)	◯ 3.5mg vial			
◯ **VIDAZA®** (azacytidine)	◯ 100mg vial			
◯ **YERVOY®** (ipilimumab)	◯ 10mL vial (5mg/mL) ◯ 40mL vial (5mg/mL)			
◯ **ZALTRAP®** (ziv-aflibercept)	◯ 100mg vial ◯ 200mg vial			
◯ **ZOLEDRONIC ACID**	◯ 4mg/100mL vial			
◯ **OTHER:**				

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: Date	Prescriber Signature: Date
Substitution Permitted	Dispense as Written

If brand is required, please write "DAW" in the box to the right.