meijer specialty pharmacy

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IV - Oncology (A-H)

Abraxane®, Adcetris®, Alimta®, Arzerra®, Avastin®, Clolar®, Cyclophosphamide, Empliciti®, Erbitux®, Halaven®, Herceptin®

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
◯ **ABRAXANE®** (paclitaxel protein-bound)	◯ 100mg vial			
◯ **ADCETRIS®** (brentuximab vedotin)	◯ 50mg vial			
◯ **ALIMTA®** (pemetrexed)	◯ 100mg vial ◯ 500mg vial			
◯ **ARZERRA®** (ofatumumab)	◯ 100mg/5mL vial ◯ 1000mg/50mL vial			
◯ **AVASTIN®** (bevacizumab) Biosimilars: ◯ Mvasi™ ◯ Zirabev®	◯ 100mg vial ◯ 400mg vial			
◯ **CLOLAR®** (clofarabine)	◯ 20mg vial			
◯ **CYCLOPHOSPHAMIDE**	◯ 500mg vial ◯ 1g vial ◯ 2g vial			
◯ **EMPLICITI®** (elotuzumab)	◯ 300mg vial ◯ 400mg vial			
◯ **ERBITUX®** (cetuximab)	◯ 100mg/50mL vial ◯ 200mg/100mL vial			
◯ **HALAVEN®** (eribulin mesylate)	◯ 1mg/2mL vial			
◯ **HERCEPTIN®** (trastuzumab) Biosimilars: ◯ Herzuma® ◯ Ontruzant® ◯ Kanjinti™ ◯ Trazimera™ ◯ Ogivri™	◯ 150mg vial ◯ 420mg vial (biosimilars only)			

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

Substitution Permitted

Prescriber Signature:	Date

Dispense as Written

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