

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

Prescriber Information

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> 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: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> 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 _____ <input type="radio"/> lb / <input type="radio"/> kg	Height _____ <input type="radio"/> in / <input type="radio"/> cm	BSA _____ m ²	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
<input type="radio"/> MEKINIST® (trametinib)	<input type="radio"/> 0.5mg <input type="radio"/> 2mg	<input type="radio"/> Take _____ mg by mouth once daily without food (1 hour before or 2 hours after a meal)		
<input type="radio"/> NILANDRON® (nilutamide)	<input type="radio"/> 150mg	<input type="radio"/> Starter dose: Take 2 tablets by mouth daily for 30 days <input type="radio"/> Maintenance dose: Take 1 tablet by mouth daily		No Refills
<input type="radio"/> NINLARO® (ixazomib)	<input type="radio"/> 2.3mg <input type="radio"/> 3mg <input type="radio"/> 4mg	<input type="radio"/> Take _____ mg on days 1, 8 and 15 of a 28-day cycle		
<input type="radio"/> ODOMZO® (sonidegib)	<input type="radio"/> 200mg	<input type="radio"/> Take 1 tablet by mouth daily without food (1 hour before or 2 hours after a meal)		
<input type="radio"/> ONUREG® (azacitidine)	<input type="radio"/> 200mg <input type="radio"/> 300mg	<input type="radio"/> Take 300mg by mouth once daily on days 1 through 14 of each 28-day cycle <input type="radio"/> Other:	28 Day Supply	
<input type="radio"/> PHESGO™ (pertuzumab, trastuzumab, and hyaluronidase-zzxf)	<input type="radio"/> 1,200mg pertuzumab, 600mg trastuzumab, 30,000 units hyaluronidase/15mL <input type="radio"/> 600mg pertuzumab, 600mg trastuzumab, 20,000 units hyaluronidase/10mL	Starter dose: <input type="radio"/> Inject 1,200mg pertuzumab, 600mg trastuzumab and 30,000 units hyaluronidase SQ in the thigh over 8 minutes <input type="radio"/> Other: Maintenance dose: <input type="radio"/> Inject 600mg pertuzumab, 600mg trastuzumab and 20,000 units hyaluronidase SQ in the thigh over 5 minutes every 3 weeks <input type="radio"/> Other:		
<input type="radio"/> PIQRAY® (alpelisib)	<input type="radio"/> 200mg <input type="radio"/> 250mg <input type="radio"/> 300mg	<input type="radio"/> Take 300mg by mouth daily with food <input type="radio"/> Take _____ mg by mouth daily with food	28 Day Supply	
<input type="radio"/> RITUXAN HYCELA® (rituximab and hyaluronidase)	<input type="radio"/> 1,400mg rituximab, 23,400 units hyaluronidase/11.7mL <input type="radio"/> 1,600mg rituximab, 26,800 units hyaluronidase/13.4mL			
<input type="radio"/> RYDAPT® (midostaurin)	<input type="radio"/> 25mg	<input type="radio"/> Take _____ mg by mouth two times a day with food continuously <input type="radio"/> Take _____ mg by mouth two times a day with food on days _____ of cycle		
<input type="radio"/> SPRYCEL® (dasatinib)	<input type="radio"/> 20mg <input type="radio"/> 50mg <input type="radio"/> 70mg <input type="radio"/> 80mg <input type="radio"/> 100mg <input type="radio"/> 140mg	<input type="radio"/> Take _____ mg by mouth once daily		

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
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Prescriber Signature:	Date
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Substitution Permitted

Dispense as Written

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

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