

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"/> AFINITOR® (everolimus)	<input type="radio"/> 2.5mg <input type="radio"/> 7.5mg <input type="radio"/> 5mg <input type="radio"/> 10mg	<input type="radio"/> Take _____ mg by mouth once daily		
<input type="radio"/> AFINITOR DISPERZ® (everolimus tablets for oral suspension)	<input type="radio"/> 2mg <input type="radio"/> 3mg <input type="radio"/> 5mg	<input type="radio"/> Take _____ mg by mouth once daily		
<input type="radio"/> CYCLOPHOSPHAMIDE (capsules)	<input type="radio"/> 25mg <input type="radio"/> 50mg			
<input type="radio"/> FARYDAK® (panobinostat)	<input type="radio"/> 10mg <input type="radio"/> 15mg <input type="radio"/> 20mg	<input type="radio"/> Take _____ mg by mouth every other day for 3 doses per week (on days 1, 3, 5, 8, 10 and 12) for the first 2 weeks of each 21-day cycle. <input type="radio"/> Other:		
<input type="radio"/> GLEEVEC® (imatinib mesylate)	<input type="radio"/> 100mg <input type="radio"/> 400mg	<input type="radio"/> Take _____ mg by mouth once daily. <input type="radio"/> Take _____ mg by mouth two times a day <input type="radio"/> Other:		
<input type="radio"/> HERCEPTIN HYLECTA™ (trastuzumab and hyaluronidase-oysk)	<input type="radio"/> 600mg trastuzumab/10,000 units hyaluronidase	<input type="radio"/> Inject 600mg/10,000 units SQ over 2-5 minutes once every 3 weeks <input type="radio"/> Other:		
<input type="radio"/> KISQALI® (ribociclib)	<input type="radio"/> 200mg <input type="radio"/> 400mg <input type="radio"/> 600mg	<input type="radio"/> Take _____ mg by mouth once daily for 21 days, followed by 7 days of rest		
<input type="radio"/> KISQALI® FEMARA® CO-PACK (ribociclib + letrozole)	<input type="radio"/> 200mg/2.5mg <input type="radio"/> 600mg/2.5mg <input type="radio"/> 400mg/2.5mg	<input type="radio"/> Start both medications on the same day: Kisqali: Take _____ mg by mouth once daily for 21 days, followed by 7 days of rest Femara: Take 1 tablet by mouth daily for 28 days		
<input type="radio"/> LUPRON DEPOT® (leuprolide acetate for depot suspension)	<input type="radio"/> 7.5mg (1 month) <input type="radio"/> 22.5mg (3 months) <input type="radio"/> 30mg (4 months) <input type="radio"/> 45mg (6 months)	<input type="radio"/> Administer 1 injection every 4 weeks <input type="radio"/> Administer 1 injection every 12 weeks <input type="radio"/> Administer 1 injection every 16 weeks <input type="radio"/> Administer 1 injection every 24 weeks		

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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