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| Attention:                                     Need By Date:                 First Ship To: [ ]  Patient [ ]  Physician |
| Patient | Patient Name:                                    DOB:                 Sex: [ ]  Male [ ]  Female Address:                                City:                 State:                 Zip:           Home#:                 Work #:                 Cell#:                 Best time to call: [ ]  AM [ ]  PMSoc. Sec #:           -          -           Ethnicity:                 Primary Language:                Allergies:                                                                             [ ]  NKDA |
| Provider | Physician Name:                     Practice Name:                State Lic#:            DEA#:           Address:                          City:                State:           Zip:           NPI#:           Phone#:                 Fax#:                 Nurse/Key Office Contact:                 Ext.:            |
| Insurance | Primary Insurance:                      ID:                      Phone:                     Secondary Insurance:                      ID:                      Phone:                     \* Please provide a copy of the insurance card (front and back) and MEDICATION LIST |
| Clinical Info | Diagnosis:                           (ICD-10):                      Naïve to Treatment: [ ]  Yes [ ]  No ER+: [ ]  Yes [ ]  No HER2: [ ]  Positive [ ]  Negative Metastatic: [ ]  Yes [ ]  No Serum Creatinine:      (     /     /     ) HgB:      (     /     /     ) HCT:      (     /     /     )Renal Dysfunction: [ ]  Yes [ ]  No Liver Dysfunction: [ ]  Yes [ ]  No*To expedite prior authorization services, please attach Chemo regimen/schedule, last clinical notes and labs* |
| **Prescription** |
| **Oral Oncolytics** Weight:            (KG) Height:            (CM) BSA:            (M2) |
| [ ]  Afinitor®[ ]  Afinitor®  Disperz[ ]  Exjade®[ ]  Gleevec®[ ]  Hycamtin®[ ]  Jadenu®[ ]  Mekinist®  | [ ]  Nexavar®[ ]  Promacta®[ ]  Sprycel®[ ]  Stivarga®[ ]  Tafinlar®[ ]  Targretin®[ ]  Tasigna® | [ ]  Temodar®[ ]  Tykerb®[ ]  Vidaza®[ ]  Votrient®[ ]  Xeloda®[ ]  Zolinza®[ ]  Zydelig™ |
| Strength:                      Quantity:                 Directions:                                         Refill #:                      |
| **Antiemetics**: [ ]  Zofran | ODT [ ]  Sancuso Dose:            SIG:                 QTY:       Refills:       |
| Physicians Signature:                                Date:                I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. |