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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  PM  Soc. 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. | | | |