

Ship to: Patient Physician / Clinic Date Shipment Needed: _____ Rx: New Refill _____

PATIENT INFORMATION

 Patient's Full Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 Patient's Social Security Number: _____
 Patient's Date of Birth: _____
 Allergies: _____
 Patient's Gender (Male or Female): _____

Diagnosis: _____ **ICD10 Code:** _____

Patient Weight: _____ Height: _____

Primary Insurance: _____

ID #: _____ Phone: _____

Secondary Insurance: _____

ID #: _____ Phone: _____

OR PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)
PRESCRIPTION INFORMATION
 Pomalyst Revlimid Thalomid Female Child - NOT of Reproductive Potential Adult Female - NOT of Reproductive Potential
 Dose: _____ Qty: _____ Sig: _____ Female Child - Reproductive Potential Adult Female - Reproductive Potential
 Male Child Adult Male
 Authorization: _____ Date: _____ Confirmation #: _____ Date: _____ (Pharmacy Use Only)
 Dexamethasone Dose: _____ Qty: _____ Directions: _____

 Zytiga 250mg 4 QD (on empty stomach) Qty: _____ Refill: _____
 WITH Prednisone 5mg BID with food Qty: _____ Refill: _____

 I.V.I.G.

ORAL DRUGS

<input type="checkbox"/> Afinitor	<input type="checkbox"/> Kisqali	<input type="checkbox"/> Odomzo	<input type="checkbox"/> Tykerb
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Pomalyst	<input type="checkbox"/> Venclexta
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Ibrance	<input type="checkbox"/> Revlimid	<input type="checkbox"/> Votrient
<input type="checkbox"/> Bosulif	<input type="checkbox"/> Imbruvica	<input type="checkbox"/> Rydapt	<input type="checkbox"/> Xalkori
<input type="checkbox"/> Cabometyx	<input type="checkbox"/> Inlyta	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Xeloda
<input type="checkbox"/> Cometriq	<input type="checkbox"/> Iressa	<input type="checkbox"/> Stivarga	<input type="checkbox"/> Xtandi
<input type="checkbox"/> Cotellic	<input type="checkbox"/> Jadenu	<input type="checkbox"/> Sutent	<input type="checkbox"/> Zelboraf
<input type="checkbox"/> Erivedge	<input type="checkbox"/> Jakafi	<input type="checkbox"/> Tamoxifen	<input type="checkbox"/> Zolanza
<input type="checkbox"/> Evista	<input type="checkbox"/> Lonsurf	<input type="checkbox"/> Tafinlar	<input type="checkbox"/> Zydelig
<input type="checkbox"/> Fareston	<input type="checkbox"/> Mekinist	<input type="checkbox"/> Tagrisso	<input type="checkbox"/> Zykadia
<input type="checkbox"/> Farydak	<input type="checkbox"/> Nexavar	<input type="checkbox"/> Tarceva	<input type="checkbox"/> Zytiga
<input type="checkbox"/> Faslodex	<input type="checkbox"/> Ninlaro	<input type="checkbox"/> Tassigna	
<input type="checkbox"/> Femara	<input type="checkbox"/> Nolvadex	<input type="checkbox"/> Temodar	
<input type="checkbox"/> Gleevec	<input type="checkbox"/> Noxafil	<input type="checkbox"/> Thalomid	

DOSE/QUANTITY/DIRECTION:

Refill #: _____

INJECTABLES
 Aranesp Neulasta
 Arixtra Neupogen
 Folutyn Nplate
 Fragmin Perjeta
 Leukine Procrit
 Lovenox Sandostatin
 Lupron Sylatron

IV INFUSION
 5FU (Fluorouracil)
 Alimta
 Avastin
 Cyclophosphamide
 Darzalex
 Doxorubicin
 Empliciti
 Erbitux
 Gazyva
 Kadcyła
 Herceptin
 Reclast
 Rituxan
 Taxotere

SUPPORT DRUGS
 Aspirin
 Allopurinol
 Coumadin
 Dexamethasone
 Emend
 Granix
 Jadenu
 Prednisone
 Promacta
 Rasburicase
 Sancuso
 Zarxio
 Zofran

ADJUNCT THERAPY
 Casodex Trelstar
 Eulexin Vantas
 Firmagon Zoladex
 Lupron Depot
 Nilandron

DOSE/QUANTITY/DIRECTION:

Refill #: _____

PRESCRIBER INFORMATION

 Physician's Name (Please Print): _____ NPI #: _____ License #: _____
 Address, City, State, Zip: _____ DEA #: _____
 Phone: _____ Fax: _____ Contact Name: _____
 Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.