

 Please cut along the dotted lines before submitting to a pharmacy.

Date Required: \_\_\_\_\_ Ship To: Patient MD Office Other: \_\_\_\_\_

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Home Phone: _____	Phone: _____
Cell Phone: _____	Fax: _____
Date of Birth: _____ Gender: _____	DEA #: _____ NPI #: _____
Emergency Contact: _____ Phone: _____	Contact Person: _____

**INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)**

Primary Insurance: _____	ID: _____	Group: _____
Secondary Insurance: _____	ID: _____	Group: _____
Prescription Card: _____	ID: _____	BIN: _____ PCN: _____

**To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:**

**PATIENT DIAGNOSIS/CLINICAL INFORMATION**

ICD-10 Code: _____	TB/PPD Test: Positive Negative	Date Read: _____
Diagnosis: _____	Weight: _____ kg lbs	Height: _____ cm in %BSA: _____
Prior Medication: _____	Allergies: _____	NKDA _____
Length of Treatment: _____	Injection Training/Home Health RN visit is necessary. Yes No	
Reason for Discontinuation: _____	Site of Care: Home MD Office Other:	

**PRESCRIPTION INFORMATION**

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
Keytruda®	100 mg/4 mL vial	Infuse 200mg IV minutes every 3 weeks Infuse 400mg IV minutes every 6 weeks		
Imfinzi®	120 mg/ 2.4mL vial 500 mg/ 10mL vial	Patients >= 30 kg: Infuse 10mg/kg IV every 2 weeks Patients >=30 kg: Infuse 1500mg IV every 4 weeks Patients < 30 kg: Infuse 10mg/kg IV every 2 weeks Patients < 30 kg: Infuse 20mg/kg IV every 4 weeks		
Darzalex®	100 mg/ 5mL vial 400 mg/ 20mL vial	Infuse 16 mg/kg of actual body weight IV every week for total of 8 doses, then every 2 weeks from weeks 9 to 24 for a total of 8 doses, then every 4 weeks from week 25 onwards		
Jemperli®	500 mg/10 mL vial	Infuse 500 mg IV every 3 weeks for 4 cycles, then 1000 mg IV every 6 weeks thereafter		
Libtayo®	350 mg/7 mL vial	Infuse 350 mg IV every 3weeks Infuse 350 mg IV every 3 weeks for 12 weeks, then 700 mg IV every 6 weeks		
Loqtorzi®	240 mg/6 mL vial	3 mg/kg IV every 2 weeks      240 mg IV every 3 weeks		
Opdivo®	40 mg/4 mL vial 100 mg/10 mL vial 120 mg/12 mL vial 240 mg/24 mL vial	Infuse 240 mg IV every 2 weeks Infuse 360 mg IV every 3 weeks Infuse 480 mg IV every 4 weeks		
Rybrevent®	350 mg/7 mL vial	Patients < 80 kg: Infuse 1050 mg IV every week for a total of 5 doses (For Week 1- split infusion on Day 1 and Day 2), then week 6 – no dose, then every 2 weeks starting at week 7 onwards Patients >= 80 kg: Infuse 1400 mg IV every week for a total of 5 doses (For Week 1- split infusion on Day 1 and Day 2), then week 6 – no dose, then every 2 weeks starting at week 7 onwards		
Tecentriq®	840 mg/14 mL vial 1200 mg/20 mL vial	Infuse 840 mg IV every 2 weeks Infuse 1200 mg IV every 3 weeks Infuse 1680 mg IV every 4 weeks		
Zynyz®	500 mg/20 mL vial	Infuse 375 mg IV every 3 weeks Infuse 500 mg IV every 4 weeks		
Other:				

**PREMEDICATION ORDERS/OTHER MEDICATIONS**

<b>Flush Protocol</b> NaCl 0.9% 5mL      Heparin 100 units per mL NaCl 0.9% 10mL      250mL 0.9% NaCl for hydration Heparin 10 units per mL	<b>Premedications &amp; Other Medications</b> Infusion supplies as per protocol      Acetaminophen _____ mg PO prior to infusion Anaphylaxis Kit orders as per protocol      Diphenhydramine _____ mg PO Other: _____
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*By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.*

**Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_**