

 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:
Darzalex Faspro®	1800 mg/30000 units vial	Inject 1800 mg/30000 units SUBQ 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 Other: _____		
Keytruda Qlex®	395 mg/4800 units vial 790 mg/9600 units vial	Inject 395 mg/4800 units SUBQ every 3 weeks Inject 790 mg/9600 units SUBQ every 6 weeks Other: _____		
Opdivo Qvantig®	600 mg/10000 units vial	Inject 600 mg/10000 units SUBQ every 2 weeks Inject 900 mg/15000 units SUBQ every 3 weeks Inject 1200 mg/20000 units SUBQ every 4 weeks		
Rybrevant Faspro®	1600 mg/20000 units vial 2240 mg/28000 units vial 2400 mg/30000 units vial 3520 mg/44000 units vial	Patient < 80 kg: Inject 1600 mg/20000 units SUBQ every week for a total of 4 doses, then every 2 weeks starting at week 5 onwards Patient >= 80 kg: Inject 2240 mg/28000 units SUBQ every week for a total of 4 doses, then every 2 weeks starting at week 5 onwards Patient < 80 kg: Inject 1600 mg/20000 units SUBQ every week for a total of 4 doses, then inject 3520 mg/44000 units SUBQ every 4 weeks starting at week 5 onwards Patient >= 80 kg: Inject 2240 mg/28000 units SUBQ every week for a total of 4 doses, then inject 4640 mg/58000 units SUBQ every 4 weeks starting at week 5 onwards Other: _____		
Tecentriq Hybreza®	1875 mg/30000 units vial	Inject 1875 mg/30000 units SUBQ every 3 weeks		
Other:	_____	_____		

PREMEDICATION ORDERS/OTHER MEDICATIONS

Premedications & Other Medications

Infusion supplies as per protocol Acetaminophen _____ mg PO prior to infusion Other: _____

Anaphylaxis Kit orders as per protocol Diphenhydramine _____ mg PO

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: _____