ADVOCATE PHARMACY

Phone: 215-362-2479
535 South Broad Street Lansdale PA 19446

Oncology

Prescription & Pharmacy Intake Form

Provider Representative | **Phone** | **Date Needed** | **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐ Other

PATIENT INFORMATION

Patient Name: ______________ DOB: __________ ☐ Male ☐ Female
Address: ______________
City: ______________ State: ________ Zip Code: __________
Phone # (Daytime): ______________ Phone # (Evening): ______________
E-mail Address: ______________ Case Manager: ______________
Insurance Provider **(Please include copy of front and back of card):** ______________
ID#: __________ Policy/Group #: ______________ Phone #: ______________
Name of Insured: ______________ Employer: ______________
Relationship to Patient: ☐ Self ☐ Other: ______________ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: ______________ Policy/Group #: ______________

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date: __________)
Primary ICD-9 Code: __________
Dinagnosis & Date: __________
Current Weight: __________
Date: __________
Current Height: __________
Date: __________
BSA: __________ π^2
Other Health Conditions: __________
Allergies: __________
Concomitant Medications: __________

PRESCRIPTION INFORMATION

Medication			Dose/Directions/Freq	Qty	Refills
☐ Afinitor®	☐ Femara®	☐ Gleevec®			
☐ Hycamtin®	☐ Nexavar®	☐ Sprycel®			
☐ Sutent®	☐ Tarceva®	☐ Targretin®			
☐ Tasigna®	☐ Temodar®	☐ Tykerb®			
☐ Votrient™	☐ Xalkori®	☐ Xeloda®			
☐ Zetboraf®	☐ Zytiga™	☐ Mozobil®			
☐ Prednisone	☐ Dexamethasone				
☐ Other: __________					
☐ Afinitor®	☐ Femara®	☐ Gleevec®			
☐ Hycamtin®	☐ Nexavar®	☐ Sprycel®			
☐ Sutent®	☐ Tarceva®	☐ Targretin®			
☐ Tasigna®	☐ Temodar®	☐ Tykerb®			
☐ Votrient™	☐ Xalkori®	☐ Xeloda®			
☐ Zetboraf®	☐ Zytiga™	☐ Mozobil®			
☐ Prednisone	☐ Dexamethasone				
☐ Other: __________					
☐ Revlimid®					

RevAssist MDAuth#: ______________ Date: __________
☐ Adult Female-NOT of Childbearing Potential ☐ Adult Female - Childbearing Potential ☐ Adult Male
☐ Female Child-NOT of Childbearing Potential ☐ Female Child - Childbearing Potential ☐ Male Child

Thalomid®			

Thalomid STEPS Program MD Auth #: ______________ Date: __________

PRESCRIBER INFORMATION

Prescriber's Name: ______________ Practice/Facility Name: ______________
Address: ______________ Office Contact: ______________
City: ______________ State: __________ Zip Code: ______________
Phone #: ______________ Fax: ______________ Best Time to Call: ______________
State Licenses #: __________ DEA #: __________ NPI#: __________ Medicaid UPIN #: __________
In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary,"** or your state specific required language to prohibit substitution: ______________
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: ______________ Date: __________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare, It bring-faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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Drug names are the property of their respective owners.

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