

Prescriber Information

Prescriber Name:		MD	DO	NP	PA	NPI:
Office Contact:		Practice Name / Collaborating MD:				
Address:		City:		State:		Zip:
Phone:	Fax:					

Patient Information • PLEASE SEND COPY OF INSURANCE CARD

Patients Name:		Last 4 Digits of SS#:	DOB: / /	Sex: M F	Weight:	Height:	Diabetic? Y N
Address:		City:		State:		Zip:	
Home Phone:		Work/Cell:	HIPAA Contact:		Emergency #:		
Interpreter Needed? Y N	Allergies: Y N If Yes, list allergies:						

Insurance Information

Primary Insurance:	Policy ID:	Group #:	BIN:	PCN:
Policyholder Name:		Policyholder DOB: / /		

Clinical Information • PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10 Code:	Weight: lb / kg	Height: in / cm	BSA m2	Diagnosis Date: / /
Current Scr or current GFR ml/min	Confirmed Mutations:			
Prior Therapy:	Reason for Discontinuation of Therapy:	Approximate Start Date	Approximate End Date	

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
AFINITOR® (everolimus)	2.5mg tablet 5mg tablet 7.5mg tablet 10mg tablet	Take ____mg by mouth once daily Other:		
AFINITOR DISPERZ® (everolimus for oral suspension)	2mg tablet 3mg tablet 5mg tablet	Take ____mg by mouth once daily Other:		
COTELIC® (cobimetinib)	20mg tablet	Take 3 tablets (60mg) by mouth once daily for the first 21 days of each 28-day cycle Other:		
CYCLOPHOSPHAMIDE	25mg capsule 50mg capsule			
DARZALEX FASPRO® (daratumumab and hyaluronidase-fihj)	15ml single dose vial (120mg daratumumab, 2,000u hyaluronidase/ml)			
ERLOTINIB (generic Tarceva®)	25mg tablet 100mg tablet 150mg tablet	Take ____mg by mouth once daily on an empty stomach Other:		
GLEEVEC® (imatinib)	100mg tablet 400mg tablet	Take ____mg by mouth ____ times a day Other:		
GLEOSTINE® (lomustine)	40mg capsule			
HYCAMTIN® (topotecan)	0.25mg capsule 1mg capsule	Take ____mg by mouth once daily for 5 days, starting on day 1 of a 21-day cycle Other:		
MEKINIST® (trametinib)	0.5mg tablet 2mg tablet 0.05mg/ml solution	Take ____mg by mouth once daily without food (at least 1 hour before or 2 hours after a meal) Other:		

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature	Date	Prescriber Signature	Date
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Substitution Permitted

Dispense as Written

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