

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
COTELLIC® (cobimetinib)	20mg tablet	Take 3 tablets (60mg) by mouth once daily for the first 21 days of each 28-day cycle Other:		
ERIVEDGE® (vismodegib)	150mg capsule	Take 150mg (1 capsule) by mouth once daily 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:		
ODOMZO® (sonidegib)	200mg capsule	Take 200mg (1 capsule) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal		
TAFINLAR® (dabrafenib)	50mg capsule 75mg capsule 10mg tablet for oral suspension	Take 150mg (2 capsules) by mouth two times a day without food (at least 1 hour before or 2 hours after a meal) Take ___mg by mouth two times a day without food (at least 1 hour before or 2 hours after a meal) Other:		
ZELBORAF® (vemurafenib)	240mg tablet	Take 960mg (4 tablets) by mouth twice daily, approximately 12 hours apart 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

If brand is required, please write "DAW" in the box to the right.