meijer specialty pharmacy

P: 800-657-2212 • F: 888-592-7723
www.meijerspecialtypharmacy.com

○ New/Changed Dose

Oncology (M-S)

Mekinist®, Nilandron®, Ninlaro®, Odomzo®, Onureg®, Phesgo™, Piqray®, Rituxan Hycela®, Rydapt®, Scemblix®, Sorafenib, Sprycel®

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:	HIPPA 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
○ **MEKINIST®** (trametinib)	○ 0.5mg ○ 2mg	○ Take_____ mg by mouth once daily without food (1 hour before or 2 hours after a meal)		
○ **NILANDRON®** (nilutamide)	○ 150mg	○ **Starter Dose:** Take 2 tablets by mouth daily for 30 days ○ **Maintenance Dose:** Take 1 tablet by mouth daily		**No Refills**
○ **NINLARO®** (ixazomib)	○ 2.3mg ○ 3mg ○ 4mg	○ Take_____ mg on days 1, 8 and 15 of a 28-day cycle		
○ **ODOMZO®** (sonidegib)	○ 200mg	○ Take 1 tablet by mouth daily without food (1 hour before or 2 hours after a meal)		
○ **ONUREG®** (azacitidine) ○ Blister Pack ○ Bottle	○ 200mg ○ 300mg	○ Take 300mg by mouth once daily on days 1 through 14 of each 28-day cycle ○ Other:	**28 Day Supply**	
○ **PHESGO™** (pertuzumab, trastuzumab, and hyaluronidase-zzxf)	○ 1,200mg pertuzumab, 600mg trastuzumab, 30,000 units hyaluronidase/15mL	**Starter Dose:** ○ Inject 1,200mg pertuzumab, 600mg trastuzumab and 30,000 units hyaluronidase SQ in the thigh over 8 minutes ○ Other:		
	○ 600mg pertuzumab, 600mg trastuzumab, 20,000 units hyaluronidase/10mL	**Maintenance Dose:** ○ Inject 600mg pertuzumab, 600mg trastuzumab and 20,000 units hyaluronidase SQ in the thigh over 5 minutes every 3 weeks ○ Other:		
○ **PIQRAY®** (alpelisib)	○ 200mg ○ 250mg ○ 300mg	○ Take 300mg by mouth daily with food ○ Take_____ mg by mouth daily with food	**28 Day Supply**	
○ **RITUXAN HYCELA®** (rituximab and hyaluronidase)	○ 1,400mg rituximab, 23,400 units hyaluronidase/11.7mL ○ 1,600mg rituximab, 26,800 units hyaluronidase/13.4mL			
○ **RYDAPT®** (midostaurin)	○ 25mg	○ Take_____ mg by mouth two times a day with food continuously ○ Take_____ mg by mouth two times a day with food on days _____ of cycle		
○ **SCEMBLIX®** (asciminib)	○ 20mg ○ 40mg	○ Take 40mg by mouth two times a day without food ○ Take 80mg by mouth daily without food ○ Take 200mg by mouth two times a day without food ○ Other:		
○ **SORAFENIB** (generic Nexavar®)	○ 200mg	○ Take 2 tablets by mouth two times a day without food (1 hour before or 2 hours after a meal) ○ Other:		
○ **SPRYCEL®** (dasatinib)	○ 20mg ○ 50mg ○ 70mg ○ 80mg ○ 100mg ○ 140mg	○ Take_____ mg by mouth once daily		

Injection Training

○ Patient received injection training	○ Prescriber's office to provide injection training	○ Meijer to coordinate injection training

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

Substitution Permitted

Dispense as Written

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