

New/Changed Dose

Cancer – General (N-Z) | Rubraca®, Rydapt®, Sorafenib, Sunitinib, Tafinlar®, Temodar®, Votrient®

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

Patient's 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 \_\_\_\_\_
Confirmation Mutations \_\_\_\_\_
Prior Therapy \_\_\_\_\_
Reason for Discontinuation of Therapy \_\_\_\_\_
Approximate Start Date \_\_\_\_\_
Approximate End Date \_\_\_\_\_

**Prescription Information**

Medication	Dose/Strength	Sig	Quantity	Refills
<b>RUBRACA®</b> (rucaparib)	200 mg tablet 250 mg tablet 300 mg tablet	Take 600 mg by mouth two times a day with or without food Other: _____		
<b>RYDAPT®</b> (midostaurin)	25 mg capsule	Take ___ mg by mouth two times a day with food Other: _____		
<b>SORAFENIB</b> (generic Nexavar®)	200 mg tablet	Take 400 mg (2 tablets) by mouth two times a day without food Other: _____		
<b>SUNITINIB</b> (generic Sutent®)	12.5 mg capsule 25 mg capsule 37.5 mg capsule 50 mg capsule	Take ___ mg by mouth once daily Take ___ mg by mouth once daily for the first 4 weeks of a 6-week cycle Other: _____		
<b>TAFINLAR®</b> (dabrafenib)	50 mg capsule 75 mg capsule 10 mg tablet for oral suspension	Take 150 mg (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: _____		
<b>TEMODAR®</b> (temozolomide)	5 mg capsule 20 mg capsule 100 mg capsule 140 mg capsule 180 mg capsule 250 mg capsule			
<b>VOTRIENT®</b> (pazopanib)	200 mg tablet	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 Community Memorial Healthcare and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature \_\_\_\_\_

Prescriber Signature \_\_\_\_\_

Date \_\_\_\_\_ *Substitution Permitted*

Date \_\_\_\_\_ *Dispense as Written*

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