

New/Changed Dose

Cancer – Skin | Cotellic®, Erivedge®, Mekinist®, Odomzo®, Tafinlar®, Zelboraf®

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 |
|-----------------------------------|--|---|----------|---------|
| COTELLIC® (cobimetinib) | 20 mg tablet | Take 3 tablets (60 mg) by mouth once daily for the first 21 days of each 28-day cycle Other: _____ | | |
| ERIVEDGE® (vismodegib) | 150 mg capsule | Take 150 mg (1 capsule) by mouth once daily Other: _____ | | |
| MEKINIST® (trametinib) | 0.5 mg tablet 2 mg tablet 0.05 mg/ml solution | Take ___ mg by mouth once daily without food (at least 1 hour before or 2 hours after a meal) Other: _____ | | |
| ODOMZO® (sonidegib) | 200 mg capsule | Take 200 mg (1 capsule) by mouth once daily on an empty stomach, at least 1 hour before or 2 hours after a meal | | |
| TAFINLAR® (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: _____ | | |
| ZELBORAF® (vemurafenib) | 240 mg tablet | Take 960 mg (4 tablets) by mouth twice daily, approximately 12 hours apart 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.