RX BIOTECH SPECIALTY PHARMACY
an aureus company

P: 800.657.2212 • F: 888.601.0049
www.RxBiotech.com

Oncology

Physician Information

Send updates to: ◯ Fax: ________ ◯ Email: ________ ◯ Text: ________

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:		Practice Name / Supervising 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:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯Y ◯N		

Insurance Information

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

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

Diagnosis:	ICD-10:	Patient's Previous Treatment:	
Urine Drug Screen Attached: ◯Y ◯N	Date of Diagnosis: / /	Transplant: ◯Y ◯N	Transplant Type:
Is Patient Currently on Therapy: ◯Y ◯N	Medications:	Will patient stop taking the prescribed medication(s) before starting the new medication? ◯ Y ◯ N	
TREATMENT ARRANGEMENTS:	Ship Meds: ◯Home ◯Doctor's Office	Start Date: / /	*Counseling and education provided by Aureus's Clinical Team

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **ANTIEMETICS®** ◯ Compazine ◯ Zofran ◯ Emend ◯ Sancuso TP ◯ Other:				
◯ **ARANESP®**			28 Day Supply	
◯ **GLEEVEC®**	◯100mg tablet ◯400mg tablet ◯Other:	◯Take __________ mg po _________ times a day with a meal and a large glass of water	30 Day Supply	
◯ **NEULASTA®**	◯PFS 6mg single 0.6mL ◯OnPro Kit		28 Day Supply	
◯ **NEUMEGA®**	◯5mg Vial ◯Other:		28 Day Supply	
◯ **NEUPOGEN®**	◯300mg SQ ◯480mg SQ ◯Other:	◯Inject 300mcg SQ ______ times a week ◯Inject 480mcg SQ ______ times a week	28 Day Supply	
◯ **NEXAVAR®**	◯200mg tab	◯Take 400mg (2x200mg) tablets po twice daily without food	28 Day Supply	
◯ **PROCRIT®**	◯40,000 units ◯Other:	◯Inject __________ units SQ __________ times a week	28 Day Supply	
◯ **SPRYCEL®**	◯20mg tablet ◯50mg tablet ◯70mg tablet ◯Other:	◯Take 100mg po once daily ◯Other:	30 Day Supply	
◯ **SUTENT®**	◯12.5mg cap ◯25mg cap ◯50mg cap ◯37.5mg cap	◯Take _____ mg po once daily for 4 weeks followed by 2 weeks off	30 Day Supply	
◯ **TARCEVA®**	◯25mg tablet ◯100mg tablet ◯150mg tablet	◯Take _____ mg po on an empty stomach once daily	30 Day Supply	
◯ **TEMODAR®**	◯5mg cap ◯20mg cap ◯100mg cap ◯140mg cap ◯180mg cap ◯250mg cap	◯Total daily dose based on BSA: _____ mg po daily for _____ days on and _____ days off, repeat every _____ days for _____ cycles. ◯Other: *Will dispense combination of different strengths based on pt's total daily doses if it is not indicated, quantity will be caculated for each strength based on sig/cycle.* *Labs to be monitored by MD and doses to be modified based on ANC and platelet level.*		
◯ **THALOMID®**	◯50mg cap ◯100mg cap ◯150mg cap ◯200mg cap	*Will dispense combination of different strengths based on pt's total daily doses if it is not indicated, quantity will be caculated for each strength based on sig/cycle.*		
◯ **XELODA®**	◯1250mg/m2 po BID for 14 days followed by 7 days of rest (2 weeks on 1 week off)	◯ _____ of 500mg & _____ of 150mg tabs every AM & _____ of 500mg & _____ 150mg tabs every PM for _____ days followed by _____ days of rest. *Xeloda is available in 500mg and 150mg tablets. A combination of both strengths will be dispensed based on patient's total daily dose unless otherwise indicated.* *Dosage adjusted based on: creatinine clearance or combination therapy with Docetaxel and/or toxicity NCIC grads*	1 Cycle	

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

Physician Signature: Date	Physician Signature: Date
Substitution Permitted	Dispense as Written