

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 First Name: _____ Home Address: _____
 S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____
 Guardian/Caregiver: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Meds Tried & Failed: _____
 Secondary ICD-10: _____
 Allergies: _____ Concurrent Medications: _____
 Vaccination History: _____

5. Prescription Information

- | | | | | | | |
|-------------------------------------|------------------------------------|------------------------------------|-------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> AFINITOR® | <input type="checkbox"/> DAURISMO™ | <input type="checkbox"/> INTRON® A | <input type="checkbox"/> NEXAVAR® | <input type="checkbox"/> SPRYCEL® | <input type="checkbox"/> TEMODAR® | <input type="checkbox"/> XTANDI® |
| <input type="checkbox"/> ALECENSA® | <input type="checkbox"/> ERIVEDGE® | <input type="checkbox"/> INREBIC® | <input type="checkbox"/> NINLARO® | <input type="checkbox"/> STIVARGA® | <input type="checkbox"/> TYKERB® | <input type="checkbox"/> ZEJULA™ |
| <input type="checkbox"/> BALVERSA™ | <input type="checkbox"/> ERLEADA™ | <input type="checkbox"/> IRESSA® | <input type="checkbox"/> NUBEQA® | <input type="checkbox"/> SUTENT® | <input type="checkbox"/> VERZENIO™ | <input type="checkbox"/> ZELBORAF® |
| <input type="checkbox"/> BOSULIF® | <input type="checkbox"/> FARYDAK® | <input type="checkbox"/> JAKAFI® | <input type="checkbox"/> ODOMZO® | <input type="checkbox"/> TAFINLAR® | <input type="checkbox"/> VITRAKVI® | <input type="checkbox"/> ZYKADIA® |
| <input type="checkbox"/> BRAFTOVI™ | <input type="checkbox"/> FEMARA® | <input type="checkbox"/> KISQALI® | <input type="checkbox"/> PIQRAY® | <input type="checkbox"/> TAGRISSO® | <input type="checkbox"/> VOTRIENT® | <input type="checkbox"/> ZYTIGA® |
| <input type="checkbox"/> CABOMETYX® | <input type="checkbox"/> GLEEVEC® | <input type="checkbox"/> LUPRON® | <input type="checkbox"/> ROZLYTREK™ | <input type="checkbox"/> TALZENNA™ | <input type="checkbox"/> XALKORI® | <input type="checkbox"/> _____ |
| <input type="checkbox"/> COPIKTRA™ | <input type="checkbox"/> IBRANCE® | <input type="checkbox"/> MEKINIST® | <input type="checkbox"/> RUBRACA™ | <input type="checkbox"/> TARCEVA® | <input type="checkbox"/> XELODA® | |
| <input type="checkbox"/> COTELLIC™ | <input type="checkbox"/> INLYTA® | <input type="checkbox"/> MEKTOVI® | <input type="checkbox"/> RYDAPT® | <input type="checkbox"/> TASIGNA® | <input type="checkbox"/> XPOVIO™ | |

Dose: _____ Qty: _____ Refills: _____
 Sig: _____
 Cycle Days: _____ days on, _____ days off

KISQALI® dispensed with: ARIMIDEX® AROMASIN® FEMARA®

COTELLIC® dispensed with: ZELBORAF®

IBRANCE® dispensed with: XELODA® FEMARA®

VERZENIO® dispensed with: FASLODEX®

TYKERB® dispensed with: FEMARA® FASLODEX®

BRAFTOVI™ dispensed with: MEKTOVI®

- REVLIMID® THALOMID® POMALYST®
- Adult Female - NOT of Reproductive Potential Adult Female - Reproductive Potential Adult Male
- Female Child - NOT of Reproductive Potential Female Child - Reproductive Potential Male Child

Dose: _____ Qty: _____ Refills: _____
 Sig: _____
 Cycle Days: _____ days on, _____ days off
 Authorization # _____

- ADDITIONAL MEDICATIONS**
- | | | | | | |
|-----------------------------------|--|----------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> AKYNZEO® | <input type="checkbox"/> ARIXTRA® | <input type="checkbox"/> EPOGEN® | <input type="checkbox"/> JADENU™ | <input type="checkbox"/> PROCRT® | <input type="checkbox"/> ZARXIO® |
| <input type="checkbox"/> ANZEMET® | <input type="checkbox"/> DEXAMETHASONE | <input type="checkbox"/> EXJADE™ | <input type="checkbox"/> NEUPOGEN® | <input type="checkbox"/> PROMACTA® | <input type="checkbox"/> ZOFRAN® |
| <input type="checkbox"/> ARANESP® | <input type="checkbox"/> EMEND® | <input type="checkbox"/> GRANIX® | <input type="checkbox"/> PREDNISONE | <input type="checkbox"/> TAVALISSE™ | <input type="checkbox"/> _____ |

Dose: _____ Qty: _____ Refills: _____
 Sig: _____
 Cycle Days: _____ days on, _____ days off

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Account Manager

Patient Signature _____ Date ____ / ____ / ____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices to act on behalf of myself and my patient to initiate any de minimus authorization process from health plans including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____