

**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

#### IV Oncology Medications Available to Dispense

ABRAXANE®	AVASTIN®	ELOXATIN®	HERCEPTIN®	KEYTRUDA®	PACLITAXEL	SYNRIBO®	ZOMETA®
ADCENTRIS®	CARBOPLATIN	ERBITUX®	KADCLYA®	ONIVYDE®	POLIVY™	VELCADE®	
ALIMTA®	DOCETAXEL	GEMCITABINE	KANJINTI™	OPDIVO®	RITUXAN®	YERVOY®	

Medication	Dose/Strength	Directions	Inf. Cycle	Dispense	Refills	Date of Inf.

#### Supportive Medications

Medication	Dose/Strength	Directions	Inf. Cycle	Dispense	Refills	Date of Inf.

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

#### Account Manager

### 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 Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_