@pfsprx #pfsprx

VERBAL ORDER FORM
ONCOLOGY

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NPI# 1669881777 NABP# 3148839
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Today's Date ____________
Date Needed ____________

Specialty Pharmacy Expires 07/01/2023

Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

Patient Name____________ Date of Birth________ ☐ Male ☐ Female
Address____________ Apt #_____ City________ State_____ Zip______
Telephone________ Cell________ SSN________ Email________
Allergies____________ Comorbidities____________

Primary Insurance____________ ID#________ Group #________
Insured's Name____________ Employer____________
City________ State_____ Phone________

ICD-10 Diagnosis Code: ☐ ________ Weight _______ BSA ________m^2 Biopsy? ☐ Yes ☐ No Results ________
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work ________
Current medications (including OTC) with dosage and direction (or fax) ________

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AFINITOR® tablets ☐ 2 mg ☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg
ARIMIDEX® tablets ☐ 1 mg
AROMASIN® tablets ☐ 25 mg
GLEEVEC® tablets ☐ 100 mg ☐ 400 mg
HYCAMTIN® tablets ☐ 0.25 mg ☐ 1 mg
JAKAFI® tablets ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg
KISQALI FCT® tablets ☐ 200 mg ☐ 400 mg ☐ 600 mg
KISQALI FEMARA CO-PK ☐ 200 mg/2.5 mg ☐ 400 mg/2.5mg ☐ 600 mg/2.5 mg
LEUKERAN® tablets ☐ 2 mg
MATULANE® capsules ☐ 50 mg
NEXAVAR® tablet ☐ 200 mg
NINLARO® capsules ☐ 2.3 mg ☐ 3 mg ☐ 4 mg
RYDAPT® capsules ☐ 25 mg
SPRYCEL® tablets ☐ 20 mg ☐ 50 mg ☐ 70 mg ☐ 80 mg ☐ 100 mg ☐ 140 mg
STIVARGA® tablets ☐ 40 mg
SUTENT® capsules ☐ 12.5 mg ☐ 25 mg ☐ 37.5 mg ☐ 50 mg
TAMOXIFEN® tablets ☐ 20 mg
TARCEVA® tablets ☐ 25 mg ☐ 100 mg ☐ 150 mg
TASIGNA® capsules ☐ 150 mg ☐ 200 mg
THALOMID® capsules ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg
TYKERB® tablets ☐ 250 mg
VOTRIENT® tablets ☐ 200 mg
XELODA® tablets ☐ 150 mg ☐ 500 mg
XTANDI® capsules ☐ 40 mg
ZOLINZA® capsules ☐ 100 mg
ZYTIGA™ tablets ☐ 250 mg ☐ 500 mg
SIG: ____________ QTY: ______ REFILLS: ______

ABRAXANE Single Dose Vial ☐ 1100 mg
ALIMTA Single Dose Vial ☐ 100 mg ☐ 500 mg
CYCLOPHOSPHAMIDE Single Dose Vial ☐ 500 mg ☐ 1g ☐ 2g
Tabs ☐ 25 mg ☐ 50 mg
ERBITUX Single Dose Vial ☐ 100 mg/50 mL ☐ 200 mg/100 mL
FASLODEX Syringes ☐ 250 mg/5 ml
JEVTANA Kit ☐ 60 mg/1.5ml
TARGRETIN (bexarotene) ☐ 75 mg capsules ☐ 1% Gel 60 gm ☐ DAW-1
VELCADE (bortezomib) Single Dose Vial ☐ 3.5 mg ☐ DAW-1
SIG: ____________ QTY: ______ REFILLS: ______

ETOPOSIDE® solution ☐ 100 mg/5 mL ☐ 500 mg/25 mL ☐ 1 g/50 mL | **capsules** ☐ 50 mg
HERCEPTIN® ☐ 150 mg vial
RITUXAN® ☐ 100 mg/ 10mL vial ☐ 500 mg/ 50mL vial
TEMODAR® capsules ☐ 5 mg ☐ 20 mg ☐ 100 mg ☐ 140 mg ☐ 180 mg ☐ 250 mg
powder ☐ 100 mg
SIG: ____________ QTY: ______ REFILLS: ______

DARZALEX Single Dose Vial ☐ 100mg/5ml ☐ 400mg/20ml
EMPLICITI Single Dose Vial ☐ 300mg ☐ 400mg
SIG: ____________ QTY: ______ REFILLS: ______

KEYTRUDA Single Dose Vial ☐ 100mg/4ml
OPDIVO Single Dose Vial ☐ 40mg/4ml ☐ 100mg/10ml ☐ 240mg/24ml
SIG: ____________ QTY: ______ REFILLS: ______

FIRMAGON® (Degarelix for injection) ☐ 120 mg vial ☐ 80 mg vial
☐ Start Dose: 240 mg is given as two injections of 120 mg each subcutaneously
☐ Maintenance Dose: Inject 80 mg subcutaneously as a single injection every 28 days
QTY: ______ REFILLS: ______

☐ **LUPRON DEPOT®** ☐ **ELIGARD** *in a kit with prefilled dual chamber syringe*
☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg
☐ 1 Month Administration - 1 Injection of 7.5 mg intramuscular every 4 weeks
☐ 3 Month Administration - 1 Injection of 22.5 mg intramuscular every 12 weeks
☐ 4 Month Administration - 1 Injection of 30 mg intramuscular every 16 weeks
☐ 6 Month Administration - 1 Injection of 45 mg intramuscular every 24 weeks
QTY: ______ REFILLS: ______

TRELSTAR ☐ 3.75 mg ☐ 11.25 mg ☐ 22.5 mg
☐ 1 Month Administration - 1 Injection of 3.75 mg intramuscular every 4 weeks
☐ 3 Month Administration - 1 Injection of 11.25 mg intramuscular every 12 weeks
☐ 6 Month Administration - 1 Injection of 22.5 mg intramuscular every 24 weeks
QTY: ______ REFILLS: ______

NEUPOGEN® ☐ 300mcg/0.5ml PFS ☐ 480mcg/0.8ml PFS
☐ 300mcg/ml Vial ☐ 480mcg/1.6ml Vial
SIG: ____________ QTY: ______ REFILLS: ______
NEULASTA Single Dose Vial® ☐ 6mg/0.6ml
NEULASTA ONPRO KIT PFS® ☐ 6mg/0.6ml
SIG: ____________ QTY: ______ REFILLS: ______
☐ **PROCRIT®** Strength ________ SIG:__________ QTY: ____ REFILLS: ____
☐ **ARANESP®** Strength ________ SIG:__________ QTY: ____ REFILLS: ____

IBRANCE ☐ Sig: QD w/ food for 21 days, then 7 days off QTY: 21 REFILLS:______
☐ SIG: w/ Letrozole: 1 tablet (2.5 mg) QD QTY: 28 REFILLS:______

JADENU® tablets ☐ 90 mg ☐ 180 mg ☐ 360 mg
SIG: ____________ QTY: ______ REFILLS: ______

ZOLADEX® PFS ☐ 3.6 mg/ml ☐ 10.8 mg/ml
SIG: Inject 3.6 mg/ml PFS subcutaneously every 28 days QTY: ______ REFILLS: ______
SIG: Inject 10.8 mg/ml PFS subcutaneously every 12 weeks QTY: ______ REFILLS: ______

PFSP is able to fill supplemental therapy for your patients, including but not limited to antiemetics, fentanyl REMS products, and dronabinol products. Please send in a hard copy prescription for controlled medications, and fill in the following blank form for non-controlled medications.
MEDICATION:__________ SIG: __________ QTY: ____ REFILLS: ____

Prescriber's Name / Practice ____________ Office Contact____________
Address____________ Suite#______ City________ State_____ Zip______
Tel________ Fax________ Email________
License#________ NPI#________ UPIN#________ DEA#________
Prescriber's Signature (signature required. NO STAMPS)____________ **Date**________

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