

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

Medication	Dose/Strength	Sig	Cycle Days	Qty	Refills
COTELLIC®	<input type="checkbox"/> 20mg tabs		____ days on, ____ days off		
DARZALEX®	<input type="checkbox"/> 100mg/5mL SDV <input type="checkbox"/> 400mg/20mL SDV		____ days on, ____ days off		
EMPLICITI™	<input type="checkbox"/> 300mg LYO <input type="checkbox"/> 400mg LYO		____ days on, ____ days off		
FARYDAK®	<input type="checkbox"/> 10mg caps <input type="checkbox"/> 15mg caps <input type="checkbox"/> 20mg caps		____ days on, ____ days off		
INTRON A®			____ days on, ____ days off		
MEKINIST®	<input type="checkbox"/> 0.5mg tabs <input type="checkbox"/> 2mg tabs		____ days on, ____ days off		
NINLARO®	<input type="checkbox"/> 4mg caps <input type="checkbox"/> 3mg caps <input type="checkbox"/> 2.3mg caps		____ days on, ____ days off		
TAFLINAR®	<input type="checkbox"/> 50mg caps <input type="checkbox"/> 75mg caps		____ days on, ____ days off		
VELCADE®	<input type="checkbox"/> 3.5mg LYO		____ days on, ____ days off		
ZELBORAF®	<input type="checkbox"/> 240mg tabs		____ days on, ____ days off		
ALKERAN®	<input type="checkbox"/> 2mg tabs		____ days on, ____ days off		
CYCLOPHOSPHAMIDE			____ days on, ____ days off		
DEXAMETHASONE			____ days on, ____ days off		
ZOMETA®			____ days on, ____ days off		
<input type="checkbox"/>			____ days on, ____ days off		

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

Dosage: _____ Sig: _____
 Quantity: _____ Cycle Days: _____ days on, _____ days off
 Authorization Number: _____ Date: _____

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 ____ / ____ / ____