



# Oral Chemotherapy Prescription Form

Today's date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please fax to (800) 349-5058

For questions, please call ICORE Healthcare (800) 350-8119.

Check one:  New patient  Established patient  Order change

Patient name \_\_\_\_\_ Patient DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Phone # \_\_\_\_\_ Patient ID# \_\_\_\_\_

Policy holder name \_\_\_\_\_ Policy holder DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

DEA # \_\_\_\_\_ NPI # \_\_\_\_\_

Physician name \_\_\_\_\_

M.D. signature \_\_\_\_\_ (Signature required, no stamps please)

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact person \_\_\_\_\_ Phone number \_\_\_\_\_

Sex  F  M BSA(m2) \_\_\_\_\_ Patient height \_\_\_\_\_ cm Patient weight \_\_\_\_\_ kg

Primary ICD-9 Code \_\_\_\_\_ Secondary DX \_\_\_\_\_

Diagnosis (in words) \_\_\_\_\_

Allergies  NKA  Other (list): \_\_\_\_\_

Treatment / Dosage Change Reason :  Toxicity  Progression of Disease  
 Change in BSA  Other: \_\_\_\_\_

Cycle Specific Therapy  
**NO REFILLS** Cycle # \_\_\_\_\_

Maintenance Therapy  
# of Refills \_\_\_\_\_

MEDICATION	Normalized Dose (mg/m2, mg/kg, etc.)	STRENGTH/FREQUENCY	QTY	MEDICATION	Normalized Dose (mg/m2, mg/kg, etc.)	STRENGTH/ FREQUENCY	QTY
<input type="checkbox"/> ALKERAN				<input type="checkbox"/> TARCEVA			
<input type="checkbox"/> ARIMIDEX				<input type="checkbox"/> TABLOID			
<input type="checkbox"/> AROMASIN				<input type="checkbox"/> TASIGNA			
<input type="checkbox"/> CASODEX				<input type="checkbox"/> TEMODAR			
<input type="checkbox"/> CEENU				<input type="checkbox"/> TESLAC			
<input type="checkbox"/> FEMARA				<input type="checkbox"/> TARCEVA			
<input type="checkbox"/> GLEEVEC (PA Required)*				<input type="checkbox"/> TASIGNA (PA Required)*			
<input type="checkbox"/> HEXALEN				<input type="checkbox"/> TEMODAR			
<input type="checkbox"/> IRESSA				<input type="checkbox"/> THALOMID			
<input type="checkbox"/> LEUKERAN				<input type="checkbox"/> TYKERB (PA Required)*			
<input type="checkbox"/> LYSODREN				<input type="checkbox"/> VESANOID			
<input type="checkbox"/> MATULANE				<input type="checkbox"/> XELODA			
<input type="checkbox"/> MESNEX				<input type="checkbox"/> ZOLINZA (PA Required)*			
<input type="checkbox"/> MYLERAN							
<input type="checkbox"/> NEXAVAR (PA Required)*				<input type="checkbox"/> OTHER:			
<input type="checkbox"/> REVLIMID (PA Required)*				<input type="checkbox"/>			
<input type="checkbox"/> SPRYCEL (PA Required)*				<input type="checkbox"/>			
<input type="checkbox"/> SUTENT (PA Required)*				<input type="checkbox"/>			

\*Please contact ICORE for a separate prior authorization form

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS THE PRESCRIBER WRITES 'daw' IN THE BOX BELOW.

Dispense As Written