Oral Oncology Order Form

2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232
Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040
www.transcriptpharmacy.com

Patient Information

Patient name ____________________

Address ____________________

City ____________ State ______ Zip ______

Home phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug allergies ____________ ❍Male ❍ Female

Prescriber Information

Prescriber name ____________ Lic# ______

DEA# ____________ Tax ID ____________

Practice name ____________________

Address ____________________ Suite ______

City ____________ State ______ Zip ______

Office Phone ____________ Fax ____________

Insurance, Medicare or Medicaid Information

Primary Insurance ____________________

Policy # ____________ Group ____________

Insurance phone ____________________

Secondary Insurance(*If applicable*,) ____________________

Policy # ____________ Group ____________

Insurance phone ____________________

Prescription Drug Coverage Company ____________________ Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# (if avail.) ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE , PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Clinical Information

Diagnosis ____________________ ICD-9 ____________ Date of Dx ____________

Lab Values: WBC ______ ANC ______ Hgb ______ Hct ______ Plate. ______ BSA ______ Height ______ Weight ______ lbs or kgs

Please provide brief medical justification (previous treatments, failed therapies, allergies etc.) ____________________

____

Is patient currently on therapy? ❍Yes ❍ No Type/medication(s): ____________________

Will patient stop taking the above medications before starting the new medication? ❍Yes ❍No If yes, what is the washout period? ____________

Other medications patient is currently taking including OTC medsications w/ dosage & directions (or fax medication profile): ____________

Drug name	Prescription Orders (PLEASE CHECK ONE OR MORE)	Quantity	Refills
Xeloda®	Directions	Qty	Refills
Tarceva®	Directions	Qty	Refills
Temodar®	Directions	Qty	Refills
Gleevec®	Directions	Qty	Refills
Sutent®	Directions	Qty	Refills
Thalomid®	Directions	Qty	Refills
❍Procrit® vial ❍Epogen® vial ❍Neulasta® PFS ❍Neupogen® PFS ❍Aranesp® SureClick Injector	Directions	Qty	Refills
Other medication	Directions	Qty	Refills

Deliver to: ❍ Patient's home ❍MD's office ❍ 1st dose to MD's office, remaining refills to patient home

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

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Name or signature of prescriber or their authorized agent (Nurse, NP, PA, MA, Etc) **Preferred Contact Phone** **Date**