BURBANK SPECIALTY PHARMACY

201 S Buena Vista St Ste 110 Burbank, CA 91505

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PATIENT INFORMATION (Complete the following or send patient demographic sheet)	**PRESCRIBER INFORMATION**
Patient Name:	Prescriber's Name:
Address:	Contact Person:
City, State, Zip:	Phone:
Phone:	Fax:
Date of Birth	DEA:

CLINICAL INFORMATION

Please fax copy patient's lab report.

Diagnosis: _____ ICD-9: _____

Tarceva □ **25mg** □ **100mg** □ **150mg** **1 Tablet PO QD** **Refill _____**

□**Yes** □ **No** Patient has experienced disease progression despite treatment with another antineoplastic agent □ Cisplatin □ Carboplatin

□ **Yes** □ **No** Patient has a diagnosis of pancreatic cancer AND Tarceva will be used in combination with Gemzar (gemcitabine)

□ **Other _____(Please fax patient's progress note)**

Xeloda □ 500mg SIG: _____ Quantity _____ Refills_____
□ 150mg SIG: _____ Quantity _____ Refills_____
*** Start Date: _____** □ **with chemo therapy** □ **with radiation therapy**

□ Take for 14 Days followed by 7 days of rest for _____ cycles. □ Take on Monday through Friday only for ____ weeks.
□ Other: _____

Temodar Total doses of _____ mg PO Daily for _____ days.
(Temodar is available in 5mg, 20mg, 100mg, 140mg, 180mg, 250mg. A combination of above strengths will be dispensed based on patient's total daily dose unless otherwise indicated.)

□**Zofran** □ **4mg** □ **8mg** □ **4mg ODT** □ **8mg** ODT
SIG: _____ Quantity _____ Refills_____

□ **Kytril 1mg**
SIG: _____ Quantity _____ Refills_____

Temodar ____ mg Sig: _____ Qty# ___ Refill ___
Temodar ____ mg Sig: _____ Qty# ___ Refill ___
Temodar ____ mg Sig: _____ Qty# ___ Refill ___
*** Start Date: _____** □ **with chemo therapy** □ **with radiation therapy**

Caphosol
Oral Rinse
Dispense: □ 4 Boxes(12-30 days supply @4-10 times daily)
□ Other: _____
SIG: Rinse as Instucted.
QID and increase as needed (up to 10 times daily)
Refills: _____

Sutent □ **12.5mg** □ **25mg** □ **50mg**
Sig: _____ Qty: _____ Refill ___
□ For 4 weeks on and 2 weeks off

Sprycel □ **20mg** □ **50mg** □ **70mg**
Sig: _____ Qty: _____ Refill ___

PRESCRIBER SIGNATURE: _____ DATE: _____

Need By: _____ **Ship To:** □ **Patient** □ **Office** □ **Patient Pick-up**