



*Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.*

**PATIENT INFORMATION**  Deliver Here

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_ Gender:  Male  Female

Email: \_\_\_\_\_

Last 4# of SS: \_\_\_\_\_

**PRESCRIBER INFORMATION**  Deliver Here

Name: \_\_\_\_\_

State License #: \_\_\_\_\_ NPI: \_\_\_\_\_

DEA #: \_\_\_\_\_ Tax ID \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION** If available, please fax copy of prescription insurance cards with this form (front and back).  
**DIAGNOSIS AND CLINICAL INFORMATION**

Primary Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

\*\*Please include Dx Code # and description Prior Failed Meds: \_\_\_\_\_

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

PRESCRIPTION				
Name	Strength	Directions	QUANTITY	REFILLS
<input type="checkbox"/> AFINITOR				
<input type="checkbox"/> GLEEVEC				
<input type="checkbox"/> MEKINIST/TAFLINAR				
<input type="checkbox"/> SPRYCEL				
<input type="checkbox"/> SUTENT				
<input type="checkbox"/> TARCEVA				
<input type="checkbox"/> TASIGNA				
<input type="checkbox"/> TEMODAR				
<input type="checkbox"/> VOTRIENT				
<input type="checkbox"/> XELODA				
<input type="checkbox"/> ZYTIGA				
<input type="checkbox"/> OTHER				
<b>ANTIEMETICS</b>				
<input type="checkbox"/> Compazine				
<input type="checkbox"/> Emend Tri-fold		Take 1 capsule (125mg) by mouth on day 1, and take 1 capsule (80mg) by mouth on day 2 and day 3 of chemo cycle	Chemo cycle frequency: _____ days	
<input type="checkbox"/> Reglan				
<input type="checkbox"/> Sancuso Patch				
<input type="checkbox"/> Other				

**PATIENT SUPPORT PROGRAMS:** Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dispense as written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

**# of Prescriptions:** \_\_\_\_\_

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289  
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

