

**2010 MEDICARE PART D
ORAL ONCOLOGY AGENTS
PHYSICIAN FAX FORM**



ONLY the prescriber may complete this form. This form is for Medicare Part D requests.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit www.myrxassistant.com and search for the appropriate health plan formulary.

Today's Date: _____

PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Insurance ID Number:			Patient Telephone Number:		
Prescribing Physician's Name:		Physician NPI#:		Specialty:	Clinic Contact Person's Name:
Clinic Name:			Clinic Address:		
City, State, Zip:			Clinic Phone #:	Clinic Secure Fax #:	
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers					
LTC Contact Name:		LTC Phone #:		LTC Secure Fax #:	

MEDICATION REQUESTED:	Strength:
Dosing Schedule:	Expected duration of treatment:
1. Is the patient currently treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested medication started? _____	
Gleevec® (imatinib):	
1. Please indicate the patient's diagnosis. <input type="checkbox"/> Aggressive systemic mastocytosis (ASM) <input type="checkbox"/> Chronic myeloid leukemia (CML) <input type="checkbox"/> Dermatofibrosarcoma protuberans (DFSP) <input type="checkbox"/> Gastrointestinal stromal tumors (GIST) <input type="checkbox"/> Hypereosinophilic syndrome(HES) and/or chronic eosinophilic leukemia (CEL) <input type="checkbox"/> Myelodysplastic syndrome/myeloproliferative disease (MDS/MPD) <input type="checkbox"/> Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) <input type="checkbox"/> Other: (Please explain) _____	
Nexavar® (sorafenib) OR Votrient™ (pazopanib):	
1. Please indicate the patient's diagnosis. <input type="checkbox"/> Advanced renal cell carcinoma <input type="checkbox"/> Hepatocellular carcinoma that is unresectable or potentially resectable but surgery is declined <input type="checkbox"/> Other: (Please explain) _____	
Sprycel® (dasatinib) OR Sutent® (sunitinib) OR Tasisna® (nilotinib)	
1. Please indicate the patient's diagnosis. <input type="checkbox"/> Advanced renal cell carcinoma <input type="checkbox"/> Chronic myeloid leukemia (CML) <input type="checkbox"/> Gastrointestinal stromal tumors (GIST) <input type="checkbox"/> Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL) <input type="checkbox"/> Other: (Please explain) _____	
2. Has the patient had previous use of Gleevec® (imatinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tarceva® (erlotinib)	
1. Please indicate the patient's diagnosis. <input type="checkbox"/> Non small cell lung cancer (NSCLC) <input type="checkbox"/> Pancreatic cancer <input type="checkbox"/> Other: (Please explain) _____	
2. Has the patient failed at least one prior chemotherapy regimen for NSCLC <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Is Tarveca to be used concomitantly with Gemzar® (gemcitabine)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Tykerb® (lapatinib):	
1. Please indicate the patient's diagnosis. <input type="checkbox"/> Advanced or metastatic breast cancer which overexpresses HER2 <input type="checkbox"/> Other: (Please explain) _____	
2. Is Tykerb to be used concomitantly with Xeloda (capecitabine)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the patient been previously treated with other cancer agents including an anthracycline (danunarbucin, doxorubicin, epirubicin, idarubicin), a taxane (docetaxel, paclitaxel), and Herceptin® (trastuzumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
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Eagan, Minnesota 55121

TOLL FREE

Fax: 800.693.6703 Phone: 800.693.6651

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