



1. Patient Information

Patient Name:		SSN:	DOB:
Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:
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4. Prescription Information:

<input type="checkbox"/> Afinitor® (everolimus)	<input type="checkbox"/> Gleevec® (imatinib)	<input type="checkbox"/> Rubraca™ (rucaparib)	<input type="checkbox"/> Venclexta (venetoclax)
<input type="checkbox"/> Afinitor® Disperz (everolimus)	<input type="checkbox"/> Hycamtin® (topotecan)	<input type="checkbox"/> Rydapt® (midostaurin)	<input type="checkbox"/> Votrient® (pazopanib)
<input type="checkbox"/> Allopurinol (allopurinol)	<input type="checkbox"/> Iressa® (gefitinib)	<input type="checkbox"/> Sprycel® (dasatinib)	<input type="checkbox"/> Xeloda® (capecitabine)
<input type="checkbox"/> Arimidex® (anastrozole)	<input type="checkbox"/> Jadenu™ (deferasirox)	<input type="checkbox"/> Sylatron® (peginterferon alfa-2b)	<input type="checkbox"/> Xtandi® (enzalutamide)
<input type="checkbox"/> Cabometyx® (cabozantinib)	<input type="checkbox"/> Jakai® (ruxolitinib)	<input type="checkbox"/> Tafinlar® (dabrafenib)	<input type="checkbox"/> Zelboraf® (vemurafenib)
<input type="checkbox"/> Cotellic™ (cobimetinib)	<input type="checkbox"/> Kisqali® (ribociclib)	<input type="checkbox"/> Tarceva® (erlotinib)	<input type="checkbox"/> Zykadia™ (ceritinib)
<input type="checkbox"/> Dexamethasone® (dexamethasone)	<input type="checkbox"/> Mekinist® (trametinib)	<input type="checkbox"/> Tasigna® (nilotinib)	<input type="checkbox"/> Zolinza® (vorinostat)
<input type="checkbox"/> Exjade® (deferasirox)	<input type="checkbox"/> Ninlaro® (ixazomib)	<input type="checkbox"/> Temodar® (temozolomide)	<input type="checkbox"/> Zytiga® (abiraterone)
<input type="checkbox"/> Farydak® (panobinostat)	<input type="checkbox"/> Nolvadex® (tamoxifen)	<input type="checkbox"/> Tykerb® (lapatinib)	Generic <input type="checkbox"/>
<input type="checkbox"/> Femara® (letrozole)	<input type="checkbox"/> Odanzo® (sonidegib)	<input type="checkbox"/> Verzenio™ (abemaciclib)	Casodex <input type="checkbox"/>
			Lupron <input type="checkbox"/>

****Please use this section for additional directions or other medications not listed****

OTHER:

STRENGTH:

DIRECTIONS (SIG):

QUANTITY: **REFILLS:**

Start of Therapy Date: **Special Delivery Instructions:**

SUPPORTIVE MEDICATIONS

<input type="checkbox"/> Aranesp® (darbepoetin alfa)	<input type="checkbox"/> Lovenox® (enoxaparin)	<input type="checkbox"/> Procrit® (epoetin alfa)	<input type="checkbox"/> Zarxio® (filgrastim-sndz)
<input type="checkbox"/> Arixtra® (fondaparinux)	<input type="checkbox"/> Neulasta® (pegfilgrastim)	<input type="checkbox"/> Promacta® (eltrombopag)	<input type="checkbox"/> Zofran® (ondansetron)
<input type="checkbox"/> Emend® (aprepitant)	<input type="checkbox"/> Neupogen® (filgrastim)	<input type="checkbox"/> Sancuso® (granisetron)	
<input type="checkbox"/> Granix® (tbo-filgrastim)	<input type="checkbox"/> Nplate® (romiplostim)	<input type="checkbox"/> Xgeva® (denosumab)	

****Please use this section for additional directions or other medications not listed****

OTHER:

STRENGTH:

DIRECTIONS (SIG):

QUANTITY: **REFILLS:**

Start of Therapy Date: **Special Delivery Instructions:**

IVIG THERAPY: (Please attach prescription)

<input type="checkbox"/> Privigen®	<input type="checkbox"/> Hizentra®	<input type="checkbox"/> Gammagard®	<input type="checkbox"/> Gammunex®-C
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Ship to: Patient Office Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:
Address:	City:	State: Zip:
Primary Office Contact:	Fax Number:	Phone Number:
Office Contact Email:		

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initiate prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

Dispense as written Substitution Permissible

Prescriber's Signature _____ Date _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.