



**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"/> <b>Afinitor®</b> (everolimus) <input type="checkbox"/> <b>Afinitor® Disperz</b> (everolimus) <input type="checkbox"/> <b>Allopurinol</b> (allopurinol) <input type="checkbox"/> <b>Arimidex®</b> (anastrozole) <input type="checkbox"/> <b>Cabometyx®</b> (cabozantinib) <input type="checkbox"/> <b>Cotellic™</b> (cobimetinib) <input type="checkbox"/> <b>Dexamethasone®</b> (dexamethasone) <input type="checkbox"/> <b>Exjade®</b> (deferasirox) <input type="checkbox"/> <b>Farydak®</b> (panobinostat) <input type="checkbox"/> <b>Femara®</b> (letrozole)	<input type="checkbox"/> <b>Gleevec®</b> (imatinib) <input type="checkbox"/> <b>Hycamtin®</b> (topotecan) <input type="checkbox"/> <b>Iressa®</b> (gefitinib) <input type="checkbox"/> <b>Jadenu™</b> (deferasirox) <input type="checkbox"/> <b>Jakai®</b> (ruxolitinib) <input type="checkbox"/> <b>Kisqali®</b> (ribociclib) <input type="checkbox"/> <b>Mekinist®</b> (trametinib) <input type="checkbox"/> <b>Ninlaro®</b> (ixazomib) <input type="checkbox"/> <b>Nolvadex®</b> (tamoxifen) <input type="checkbox"/> <b>Odanzo®</b> (sonidegib)	<input type="checkbox"/> <b>Rubraca™</b> (rucaparib) <input type="checkbox"/> <b>Rydapt®</b> (midostaurin) <input type="checkbox"/> <b>Sprycel®</b> (dasatinib) <input type="checkbox"/> <b>Sylatron®</b> (peginterferon alfa-2b) <input type="checkbox"/> <b>Tafinlar®</b> (dabrafenib) <input type="checkbox"/> <b>Tarceva®</b> (erlotinib) <input type="checkbox"/> <b>Tasigna®</b> (nilotinib) <input type="checkbox"/> <b>Temodar®</b> (temozolomide) <input type="checkbox"/> <b>Tykerb®</b> (lapatinib) <input type="checkbox"/> <b>Verzenio™</b> (abemaciclib)	<input type="checkbox"/> <b>Venclexta</b> (venetoclax) <input type="checkbox"/> <b>Votrient®</b> (pazopanib) <input type="checkbox"/> <b>Xeloda®</b> (capecitabine) <input type="checkbox"/> <b>Xtandi®</b> (enzalutamide) <input type="checkbox"/> <b>Zelboraf®</b> (vemurafenib) <input type="checkbox"/> <b>Zykadia™</b> (ceritinib) <input type="checkbox"/> <b>Zolinza®</b> (vorinostat) <input type="checkbox"/> <b>Zytiga®</b> (abiraterone) Generic <input type="checkbox"/> Casodex <input type="checkbox"/> Lupron <input type="checkbox"/>	<p><b>**Please use this section for additional directions or other medications not listed**</b></p> <input type="checkbox"/> OTHER: <b>STRENGTH:</b> <b>DIRECTIONS (SIG):</b> <b>QUANTITY:</b> <b>REFILLS:</b> <b>Start of Therapy Date:</b> <b>Special Delivery Instructions:</b>
<b>SUPPORTIVE MEDICATIONS</b>				
<input type="checkbox"/> <b>Aranesp®</b> (darbepoetin alfa) <input type="checkbox"/> <b>Arixtra®</b> (fondaparinux) <input type="checkbox"/> <b>Emend®</b> (aprepitant) <input type="checkbox"/> <b>Granix®</b> (tbo-filgrastim)	<input type="checkbox"/> <b>Lovenox®</b> (enoxaparin) <input type="checkbox"/> <b>Neulasta®</b> (pegfilgrastim) <input type="checkbox"/> <b>Neupogen®</b> (filgrastim) <input type="checkbox"/> <b>Nplate®</b> (romiplostim)	<input type="checkbox"/> <b>Procrit®</b> (epoetin alfa) <input type="checkbox"/> <b>Promacta®</b> (eltrombopag) <input type="checkbox"/> <b>Sancuso®</b> (granisetron) <input type="checkbox"/> <b>Xgeva®</b> (denosumab)	<input type="checkbox"/> <b>Zarxio®</b> (filgrastim-sndz) <input type="checkbox"/> <b>Zofran®</b> (ondansetron)	<p><b>**Please use this section for additional directions or other medications not listed**</b></p> <input type="checkbox"/> OTHER: <b>STRENGTH:</b> <b>DIRECTIONS (SIG):</b> <b>QUANTITY:</b> <b>REFILLS:</b> <b>Start of Therapy Date:</b> <b>Special Delivery Instructions:</b>
<b>IVIG THERAPY: (Please attach prescription)</b>				
<input type="checkbox"/> <b>Privigen®</b>	<input type="checkbox"/> <b>Hizentra®</b>	<input type="checkbox"/> <b>Gammagard®</b>	<input type="checkbox"/> <b>Gammunex®-C</b>	<p><b>QUANTITY:</b>      <b>REFILLS:</b>  <b>Start of Therapy Date:</b>      <b>Special Delivery Instructions:</b></p>

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 its 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 \_\_\_\_\_

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