## **LINCOLN PHARMACY**

## 831 STERLING PARKWAY, SUITE #120, LINCOLN, CA 95648

PHONE: 916-209-3618 | FAX: 916-209-3634 | www.yourlincolnpharmacy.com

Date:	ONC	COLOGY PRESCRIPTION	FORM									
		PATIENT INFORMATIO	N									
Patient Name:Address:		☐ Male ☐ Female  Date of Birth:  SSN: Phone:		Need by Date:  Ship to:								
		PRESCRIBER INFORMATI	ON									
Prescriber Name:Address:City, State, Zip:		DEA: Phone:		NPI: Fax:								
	DIAC	GNOSIS/ CLINICAL INFORI	MATION									
Weight:lbs / kg Height	te of Diagnosis/ Years with disease: ght: Albumin: ccess, Could you please provide Che		Allergies:		ction OY	es O No 						
PRESCRIPTION INFORMATION												
$\square$ INITIAL PRESCRITION	☐PREVIOUSLY DISPENSED	ORAL MEDICATION	NS									
MEDICATION	STRENGTH		DIRECTION		QTY	REFILLS						
☐ Arimidex®	☐ 1mg	Take 1 tablet daily										
☐ Aromasin®	□ 25mg	Take 1 tablet daily										
☐ Sprycel®	☐ 20mg ☐ 70mg ☐ 50mg ☐ 100mg											
□ Sutent®	☐ 12.5mg ☐ 50mg ☐ 25mg											
□ Temodar®	□ 5mg □ 140mg □ 20mg □ 180mg □ 100mg □ 250mg											
□ Xeloda®	□ 150mg □ 500mg											
☐ Other medication:												
prior authorization process and to Prescriber Signature:  Patient Support Program  By signing below, I authorize Lin programs. I authorize any common help coordinate the delivery of properties and the program of the	ncoln Pharmacy to help me en unications among my providers, the roducts and services through the va the pharmacy. However, my refusal ilized as the original signed applicati	roll in any or all patient co-pay assis pharmacy and the manufacturers rious co-pay assistance programs. I will not allow me to be enrolled in ion for any and all possible foundati	undations and manufacturer stance programs, including al regarding my health condition understand that I may refuse any co-pay assistance progra ions that may participate in the	assistance programs if ned  Do not substitute  Il foundations and manufa ans and medications prescri e to sign this form without ams. If agreed, this signed a the co-pay assistance programs	cessary.  icturer ass iptions in t affecting authorizat rams, and	sistance order to my tion form It may						
Patient Signature: Important Notice: This fax is intended to be	delivered only to the named addressee and cor	Date:ntains confidential information that is protected	d under federal and state laws. If you ε	 are not the intended recipient, plea	ase notify the	sender and						
destroy this document immediately.			,	, 71	•							

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Date:	ONC	OLOGY PRESCRIPTION	FORM				
PATIENT INFORMATION							
		☐ Male ☐ Female Date of Birth:		Need by Date:			
City, State,Zip:		Pnone:		Utner:			
PRESCRIBER INFORMATION	J.						
T NEOCHIDEN IN CHIMATION	•						
Prescriber Name:		DEA:	I	NPI:			
				ax:			
City, State, Zip:		Contact Person:					
DIAGNOSIS/ CLINICAL INFO			<u>_</u>	_			
ICD-9 Code:lbs / kg	Date of Diagnosis/ Years with disease: Height: Albumin:	Serum Creatinine:	□Liver dysfunction ○ Yes Allergies:	O No □Renal dysfu	nction O	Yes O No	
For faster Prior Authorization	on process, Could you please provide Chei	mo Regimen/ Schedule, last clinical		O Faxed			
PRESCRIPTION INFORMATI							
□INITIAL PRESCRITION	□PREVIOUSLY DISPENSED	INJECTIBLES MEDICATIONS	;				
MEDICATION	STRENGTH	DIRECTION			QTY	REFILLS	
☐ Aranesp							
☐ Arixtra							
☐ Leukine							
□ Lovenox							
Lupron							
□ Neulasta							
□ Neupogen							
☐ Procrit							
☐ Reclast							
☐ Sylatron							
☐ Other							
		ANTIEMETICS					
☐ Compazine							
☐ Emend Tri-fold		Take 1 capsule (125mg) day 1 a  ☐ Chemo cycle frequency:	nd 1 capsule (80mg) day 2 and days	3 of chemo cycle			
☐ Reglan		Chemo cycle frequency .	uays				
☐ Sancuso Patch							
☐ Other							
prior authorization process  Prescriber Signature:  Patient Support Programs:  By signing below, I authoriz  programs. I authorize any cohelp coordinate the delivery	e <b>Lincoln Pharmacy</b> to help me en ommunications among my providers, the y of products and services through the va	pate: roll in any or all patient co-pay assis pharmacy and the manufacturers rious co-pay assistance programs. I	undations and manufacturer as stance programs, including all for regarding my health conditions understand that I may refuse to	□ Do not substitute  pundations and manu  and medications pres o sign this form witho	facturer as criptions in	ssistance n order to g my	
(or a copy of this form) will serve such purpose.  Patient Signature:	from the pharmacy. However, my refusal be utilized as the original signed applicati	on for any and all possible foundati Date:	ions that may participate in the	co-pay assistance pro	grams, an	d it may	
Important Notice: This fav i	s intended to be delivered only to the nar	med addressee and contains confid	ential information that is prote	cted under federal an	d state law	s If you	

are not the intended recipient, please notify the sender and destroy this document immediately.