LINCOLN PHARMACY

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

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

Date: _____

ONCOLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Address: _____ Date of Birth: _____

City, State,Zip: _____ SSN: _____

Phone: _____

Need by Date: _____

Ship to: ☐ Patient Home

☐ Other: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Contact Person: _____

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: _____ Date of Diagnosis/ Years with disease: _____ Serum Creatinine: _____ □Liver dysfunction ○ Yes ○ No □Renal dysfunction ○ Yes ○ No

Weight: _____lbs / kg Height: _____ Albumin: _____ Allergies: _____

For faster Prior Authorization process, Could you please provide Chemo Regimen/ Schedule, last clinical note and/or lab values/scans ○ Faxed

PRESCRIPTION INFORMATION

☐**INITIAL PRESCRITION** ☐**PREVIOUSLY DISPENSED**

ORAL MEDICATIONS

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:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ ☐ **Do not substitute**

Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____

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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 and 1 capsule (80mg) day 2 and 3 of chemo cycle ☐ Chemo cycle frequency : _____ days		
☐ Reglan				
☐ Sancuso Patch				
☐ Other				

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