POLARIS SPECIALTY RX

Fax: 800.540.3400
Phone: 800.540.4700

**To ePrescribe, send prescription to:**
Polaris Specialty Pharmacy
410 Cloverleaf Drive
Baldwin Park, CA 91706
**NPI: 1053486795**

# ORAL ONCOLOGY ORDER FORM

## Patient Information

Patient Name: ______________________________ DOB: ______________ SSN: ________________

Address: ______________________________________________________________

City: ______________________________ State: ______________ Zip: ______________

Phone: ______________________________ Alt Phone: ______________________________

Email: ______________________________________________________________

Alternate Contact Info (Name and Phone): ______________________________________

Gender: ☐ Male ☐ Female Allergies: ______________________________________

**PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS**

## Clinical Information

Primary Diagnosis: ______________________________________________________

DX Date (needed for funding): ______________________ ICD-10 Code: ______________________

Secondary Diagnosis: ______________________________________________________

DX Date (needed for funding): ______________________ ICD-10 Code: ______________________

## Prescription Information

### Oral Oncology Medications

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Abiraterone Acetate | ☐ Capecitabine | ☐ Everolimus | ☐ Imatinib Mesylate | ☐ Ninlaro® | ☐ Talfinlar® | ☐ Temodar® | ☐ Xeloda® |
| ☐ Afinitor® | ☐ Deferasirox | ☐ Farydak® | ☐ Kisquali® | ☐ Orgovyx® | ☐ Tarceva® | ☐ Temozolomide | ☐ Xtandi® |
| ☐ Aromasin® | ☐ Erivedge® | ☐ Gleevec® | ☐ Lapatinib | ☐ Rydapt® | ☐ Targretin® | ☐ Tykerb® | ☐ Zytiga® |
| ☐ Bexarotene | ☐ Erlotinib | ☐ Hycamtin® | ☐ Mekinist® | ☐ Sprycel® | ☐ Tasigna® | ☐ Votrient® | |

Oral Oncology Medication Directions:

Cycles Days: ______________ days on, ______________ days off

| Quantity | Refills |
|---|---|
| # __________ ☐ Tabs ☐ Caps | __________ |

### Additional/Supportive Medications

| | | | | | |
|---|---|---|---|---|---|
| ☐ Akynzeo® | ☐ Arixtra® | ☐ Epogen® | ☐ Jadenu™ | ☐ Procrit® | ☐ Zarxio® |
| ☐ Anzemet® | ☐ Dexamethasone | ☐ Exjade™ | ☐ Neupogen® | ☐ Promacta® | ☐ Zofran® |
| ☐ Aranesp® | ☐ Emend® | ☐ Granix® | ☐ Prednisone | ☐ Tavalisse® | ☐ Other: ______________ |

Additional/Supportive Medication Directions:

______________________________________________________________

| Quantity | Refills |
|---|---|
| # __________ ☐ Tabs ☐ Caps | __________ |

## Prescriber Information

**PRIOR AUTHORIZATION**

Prescriber Name: ______________________ NPI: ______________ DEA: ______________ LIC#: ______________

Address: ______________________________________________________________

City: ______________________ Zip: __________ Tel: ______________________ Fax: ______________________

Contact Person: ______________________________________________________

**PRESCRIBER SIGNATURE**
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

I authorize Polaris Specialty Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

**Physician's Signature:** ______________________________ ☐ **Dispense as written (DAW) Date:** ______/______/______

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Updated 03/27/2024