For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

**Note:** This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

# Other Cancers

Prescription/Pharmacy Intake Form

Pharmacy: _____

Pharmacy Fax: _____ Pharmacy Phone: _____

**Date Needed:** 3-26-25 **Ship To:** ☐Prescriber's Office ☒Patient's Home ☐Other: _____

## PATIENT INFORMATION

Patient name: Tammy Alice Lynch DOB: 01-02-1966 ☐Male ☒Female

Address: 5044 Montana Lane

City: Lincoln State: VA Zip code: 20160

Phone # (Daytime): 703 801 5897 Phone # (Evening): _____

Insurance provider **(Please include copy of front and back of card)**: UnitedHealth Group

ID #: 129411982 Policy/Group #: 2553172 Phone #: 8771805800 ☐Patient is eligible for Medicare

## CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☒Patient is new to therapy ☐Patient is currently on therapy Start date: 03-26-2025

ICD-10 code: B50.9 ICD-10 description: _____

Weight: 96 ☐lb ☒kg Date: 03/13/2025 Height: 175 ☐in ☒cm Date: 03/13/25 BSA: 1.7 $m^2$

Allergies: Penicillin, Avocado

Please indicate the documents(s) attached:

☐Failed therapies ☐Recent laboratory results ☐Recent pathology report ☐Recent office notes ☐Copy of front and back of insurance card

**Colorectal Cancer:**

**BRAF mutation, V600E** ☐Positive ☒Negative

**KRAS Wild Type** ☐Positive ☒Negative

**Other:**

**Kit (CD117)** ☐Positive ☒Negative

**RET fusion** ☐Positive ☒Negative

**NTRK Gene Fusion** ☐Positive ☒Negative

**RET mutant** ☐Positive ☒Negative

| Medication | Dose/Directions/Frequency | Qty | Refills |
|---|---|---|---|
| ☐Afinitor ☐Braftovi ☐Cabometyx<br>☐Erleada ☐Erlotinib ☐Eulexin<br>☐Gavreto ☒Gleevec ☐Inlyta<br>☐Koselugo* ☐Lonsurf ☐Nexavar<br>☐Nubeqa ☐Retevmo ☐Rozlytrek<br>☐Stivarga ☐SutentA ☐Temozolomide<br>☐Votrient ☐Xeloda ☐Xtandi capsules<br>☐Xtandi tablets ☐Yonsa ☐Zytiga<br>☐Other: _____ | 25MG TAB PO QD | 30 | 1 |
| ☐Lenvima | | | |
| **If prescribing:** | | | |
| Yonsa ☐Methylprednisolone | | | |
| Zytiga ☐Prednisone | | | |
| ☐MuGard ☐Other: _____ | | | |
| ☐Akynzeo ☐Aloxi ☐Anzemet<br>☐Emend ☐Sancuso ☐Zofran<br>☐Other: _____ | | | |
| ☐Granix ☐Leukine ☐Neupogen<br>☐Neulasta ☐Zarxio<br>☐Other: _____ | | | |
| ☐Aranesp ☐Procrit<br>☐Other: _____ | | | |
| ☐Arixtra ☐Fragmin<br>☐Heparin ☐Lovenox<br>☐Other: _____ | | | |

* Available at select health system pharmacy locations only.

## PRESCRIBER INFORMATION

Prescriber's name: Evelyn Hamilton Practice/facility: St John's Healthcare Services

Address: 102 Pepper Wood Street City: Round Hill State: VA Zip code: 20141

Office contact: Samuel Moore Phone: 826-685-1994 Fax: 686 383 9940

Email: samuel.moore@stjohnshealthcareservices.org Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: 4706306971 DEA #: BH3296096 NPI #: 1944304579 Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Evelyn Hamilton 03-23-25

Dispense as written | Substitution permitted | Date

**The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.**