Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your EHR

Fax: 832-886-4298
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ONCOLOGY INFUSION

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female ○ Male
Email:		Allergies:		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy#:	Group#:

CLINICAL INFORMATION

Primary Diagnosis: _____ Diagnosis (ICD-10) _____

Cancer Stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Other: _____

Patient previously treated for this condition? ☐ Yes ☐ No Medication(s): _____

Previous Infusion Chemotherapy Treatment: ☐ Yes ☐ No If Yes, list medications: _____

Next Dose Date: _____ Therapy Start Date: _____ Length of Therapy: _____ Date of Last Infusion: _____

PRESCRIPTION INFORMATION (or attach a copy of prescription)

Infusion Chemotherapy

ABRAXANE® *(paclitaxel protein-bound)*
ADRUCIL® *(5-fluorouracil)*
ALIMTA® *(pemetrexed disodium)*
ARZERRA® *(ofatumumab)*
DARZALEX® *(daratumumab)*
DARZALEX FASPRO® *(daratumumab & hyaluronidase-fihj)*
ELOXATIN® *(oxaliplatin)*
EMPLICITI® *(elotuzumab)*
ENHERTU® *(fam-trastuzumab deruxtecan-nxki)*
ERBITUX® *(cetuximab)*
GAZYVA® *(obinutuzumab)*
GEMZAR® *(gemcitabine)*
IXEMPRA® *(ixabepilone)*
JEVTANA® *(cabazitaxel)*
KADCYLA® *(ado-trastuzumab emtansine)*
KEYTRUDA® *(pembrolizumab)*
KYPROLIS® *(carfilzomib)*
OPDIVO® *(nivolumab)*
OPDIVO QVANTIG™ *(nivolumab and hyaluronidase-nvhy)*
PARAPLATIN® *(carboplatin)*
PERJETA® *(pertuzumab)*
PLATINOL® *(cisplatin)*
TAXOL® *(paclitaxel)*
TAXOTERE® *(docetaxel)*
TECENTRIQ® *(atezolizumab)*
TORISEL® *(temsirolimus)*
VELCADE® *(bortezomib)*
YERVOY® (ipilimumab)
ZOMETA® (zolcdronic acid)

For the following please select an acceptable biosimilar:

☐ **RITUXAN®** *(rituximab)*
☐ **TRUXIMA®**
☐ **RUXIENCE®**
☐ **RIABNI™**

☐ **AVASTIN®** *(bevacizumab)*
☐ **MVASI™**
☐ **ZIRABEV™**

☐ **HERCEPTIN®** *(trastuzumab)*
☐ **KANJINTI™** ☐ **ONTRUZANT®**
☐ **HERZUMA®** ☐ **TRAZIMERA®**
☐ **OGIVRI®**

Directions: Drug Name *(write in one of the above)*: _____ ☐ Follow manufacturer guidelines
☐ Dose: _____ Frequency: _____ every _____days
Quantity: _____ Refills: _____ ☐ IV ☐ SUBQ

Directions: Drug Name *(write in one of the above)*: _____ ☐ Follow manufacturer guidelines
☐ Dose: _____ Frequency: _____ every _____days
Quantity: _____ Refills: _____ ☐ IV ☐ SUBQ

Labs **Date:** _____ **Serum Creatinine:** _____ **eGFR/CrCL:** _____

Pre-Medication

☐ **Benadryl®** *(diphenhydramine)* Strength: _____ SIG: _____ ☐ IV ☐ PO QTY: _____ Refills: _____
☐ **Decadron®** *(dexamethasone)* Strength: _____ SIG: _____ ☐ IV ☐ PO QTY: _____ Refills: _____
☐ **Pepcid®** *(famotidine)* Strength: _____ SIG: _____ ☐ IV ☐ PO QTY: _____ Refills: _____
☐ Other_____ Strength: _____ SIG: _____ ☐ IV ☐ PO QTY: _____ Refills: _____

Antiemetics ☐ Chemotherapy-induced N/V ☐ Radiation-induced N/V

☐ **ALOXI®** *(palonosetron hydrochloride)* ☐ **AKYNZEO®** (netupitant/palonosetron) ☐ **EMEND®** (aprepitant) ☐ **ANZEMET®** *(dolasteron)* ☐ **Kytril®** *(granisetron)* ☐ **ZOFRAN®** *(ondansetron)* ☐ **COMPAZINE®** *(prochlorperazine)* ☐ Other: _____
Strength: _____ SIG: _____ ☐ IV ☐ PO QTY: _____ Refills: _____

Supportive Therapy *(For the following, please select an acceptable biosimilar)*

☐ **NEUPOGEN®** *(filgrastim)* ☐ **GRANIX®** ☐ **ZARXIO®** ☐ **NIVESTYM™**
Strength: _____ SIG: _____ ☐ IV ☐ SUBQ QTY: _____ Refills: _____

☐ **PROCRIT®** *(epoetin alfa)* ☐ **RETACRIT®** ☐ **EPOGEN®**
Strength: _____ SIG: _____ ☐ IV ☐ SUBQ QTY: _____ Refills: _____

☐ **NEULASTA®** *(pegfilgrastim)* ☐ **FULPHILA®** ☐ **UDENYCA** ☐ **NYVEPRIA™** ☐ **ZIEXTENZO®**
Strength: _____ SIG: _____ ☐ IV ☐ SUBQ QTY: _____ Refills: _____

Start of Therapy Date: **Special Delivery Instructions:**

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:	
Office Contact:		Email:	
Address:	City:	State:	ZIP:
NPI #:		Tax ID:	
Prescriber Signature:		Date:	