Zarina Pharmacy
SPECIALTY & INFUSION

Medicare Part B Oncology

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name		
Address		
City State ZIP		
Main Phone	Alternate Phone	
Social Security #		
Date of Birth	☐ Female ☐ Male	

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Metastatic Disease: ☐ No ☐ Yes	HER2: ☐ Positive ☐ Negative
BSA m2	Hormone Receptor: ☐ ER Positive ☐ ER Negative ☐ PR Positive ☐ PR Negative	Treatment Status: ☐ New to Therapy ☐ Continuation of Therapy, Start Date: _____ / _____ / _____	
Prior Therapy		Length of Treatment	Reason for Discontinuing
Allergies: ☐ NKDA ☐ Other: _____			Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

Must Include Dose/Frequency/Cycle On and Off Days

			Qty	Refills
☐ Xeloda®	☐ 150 mg Tablet ☐ 500 mg Tablet	☐ Take _____ mg by mouth every 12 hours for 14 days on, then 7 days off ☐ Conjunction with radiation: Take _____ mg by mouth every 12 hours with radiation for _____ days a week for a total of _____ weeks ☐ Other: _____	____ 150 mg Tablet(s) ____ 500 mg Tablet(s)	_____ _____
☐ Temodar®	☐ 5 mg Capsule ☐ 20 mg Capsule ☐ 100 mg Capsule ☐ 140 mg Capsule ☐ 180 mg Capsule ☐ 250 mg Capsule	☐ Take _____ mg by mouth once daily for 5 days on, then 23 days off ☐ Conjunction with radiation: Take _____ mg by mouth once daily with radiation for _____ days a week for a total of _____ weeks ☐ Other: _____	____ 5 mg Capsule(s) ____ 20 mg Capsule(s) ____ 100 mg Capsule(s) ____ 140 mg Capsule(s) ____ 180 mg Capsule(s) ____ 250 mg Capsule(s)	_____ _____ _____ _____ _____ _____
☐ Other Drug Name: _____ _____ _____	Strength/Formulation: _____ _____ _____	Include Dose/Frequency/Cycle On and Off Days: _____ _____ _____	_____ _____ _____	_____ _____ _____

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

_____ _____ _____ _____

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**