Zarina Pharmacy
SPECIALTY & INFUSION

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

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

PEDIATRIC ONCOLOGY

PATIENT INFORMATION

Name:		SSN:	DOB:
Address:		City: State:	ZIP:
Home Phone:	Cell:	Email:	
Parent/Guardian Name:			Gender: ○ Female ○ Male

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 (ICD-10)	Secondary Diagnosis (ICD-10)
Height:	Weight:
Allergies:	

PRESCRIPTION INFORMATION (or attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **AFINITOR®** *(everolimus)**				
☐ **AFINITOR DISPERZ®** *(tablets for oral suspension)**				
☐ **EXJADE®** *(deferasirox)**†				
☐ **GLEEVEC®** *(imatinib)**†				
☐ **JADENU™** *(deferasirox)**†				
☐ **SPRYCEL®** *(dasatinib)**				
☐ **CABOMETYX®** *(cabozantinib)*				
☐ **Other:**				
☐ **Other:**				

Start of Therapy Date:

Ship To: ☐ Patient ☐ MD Office

*AVAILABLE IN GENERIC

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:	