Zarina Pharmacy
SPECIALTY & INFUSION

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

ONCOLOGY REMS

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

PATIENT INFORMATION

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

INSURANCE INFORMATION (or attach copy of the cards)

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

CLINICAL INFORMATION

Diagnosis: | Diagnosis Code (ICD-10):_____

Drug Allergies: | Status: ☐ New ☐ Restart ☐ Continuing

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

Patient Type (check one):

☐ Adult Female - Reproductive Potential (FRP) ☐ Adult Female - NOT of Reproductive Potential (FNRP) ☐ Adult Male

☐ Female Child - Reproductive Potential (FRP) ☐ Female Child - NOT of Reproductive Potential (FNRP) ☐ Male Child

Celgene Auth #:_____ **Date Issued:** _____

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **POMALYST®** ☐ *pomalidomide*	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	☐ Take 1 cap PO daily on days 1-21, of a 28 day cycle ☐ _____	21 _____	None
☐ **REVLIMID®** ☐ *lenalidomide*	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	☐ Take 1 cap PO daily ☐ Take 1 cap PO daily on days 1-21, of a 28 day cycle ☐ _____	28 21	None
☐ **THALOMID®** *(thalidomide)* *Supplied in blister packs of 28 caps*	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	☐ Take 1 cap PO daily ☐ _____	28 _____	None
☐ Dexamethasone	☐ 2 mg ☐ 4 mg	☐ Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ _____	28 _____	_____ _____
☐ Hemady®	20 mg	☐ Take _____ mg PO once weekly on days 1, 8, 15 and 22 of a 28 day cycle ☐ _____	28 _____	_____ _____
☐ Other				

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#:	Ship To: ◉ Patient	◯ MD Office
Prescriber Signature:	Date:		