OncoMed
The Oncology Pharmacy

MVP® HEALTH CARE

pharmacy 877.662.6633
fax 877.662.6355

Oral Rx Oncology Order Form

Patient Information

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____ email: _____

May we contact patient regarding co-pays & insurance questions? ☐ **Yes** ☐ **No**

Insurance Information (Medical Benefit)

Primary: MVP Health Care

MVP Subscriber Name: _____ MVP Member #: _____ Ph: 1-800-684-9286

Address: 625 State Street City: Schenectady State: NY Zip: 12305

Secondary: _____ Policy Holder: _____ Policy #: _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Rx Prescription

Oral Medication	Available Strengths (please check)						Directions	Quantity	Refills
GLEEVEC®	☐ 100mg	☐ 400mg							
NEXAVAR®	☐ 200mg								
REVLIMID®	☐ 5mg	☐ 10mg	☐ 15mg	☐ 25mg					
SPRYCEL®	☐ 20mg	☐ 50mg	☐ 70mg	☐ 100mg					
SUTENT®	☐ 12.5mg	☐ 25mg	☐ 50mg						
TARCEVA®	☐ 25mg	☐ 100mg	☐ 150mg						
TEMODAR®	☐ 5mg	☐ 20mg	☐ 100mg	☐ 140mg	☐ 180mg	☐ 250mg			
THALOMID®	☐ 50mg	☐ 100mg	☐ 150mg	☐ 200mg					
TYKERB®	☐ 250mg								
XELODA®	☐ 150mg	☐ 500mg							
ZOLINZA®	☐ 100mg								
AFINITOR®	☐ 10mg	☐ 20mg							
TASIGNA®	☐ 200mg								
HYCAMTIN®	☐ 0.25mg	☐ 1mg							
TAMOXIFIN®	☐ 10mg	☐ 20mg							
FEMARA	☐ 2.5mg								

Diagnosis Information

Primary Dx: _____

Stage: _____ ICD-9: _____

Secondary Dx: _____

ICD-9: _____

Patient Weight: _____ lbs Patient Height: _____

BSA: _____

Allergies: _____

Physician Information

Physician Name: _____

Contact: _____ email: _____

Street: _____

City: _____ State: _____ Zip: _____

Ph: _____ Fax: _____

NPI #: _____

Prescriber Signature (required by law) _____

Prescription will be filled with generic unless prescriber writes "DAW" (dispense as written) in the box ☐

Shipping Instructions

☑ Deliver to Patient

Date Required: _____ Preferred Delivery Time: _____ ☐ AM ☐ PM

Oral prescriptions will be billed through patient's PBM provider.