ALLIED PHARMACY

NEUROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

MAIN POINT OF CONTACT

Name:_____

Phone:_____

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____

ID#:_____ RxBin:_____ ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

☐ Afinitor (everolimus)
☐ Afinitor Disperz (everolimus)
☐ Cabometyx (cabozantinib)
☐ Gleevec (imatinib mesylate)
☐ Ibrance (palbociclib)
☐ Jakafi (ruxolitinib)
☐ Nexavar (sorafenib)
☐ Sprycel (dasatinib)
☐ Sutent (sunitinib malate)
☐ Tarceva (erlotinib HCl)
☐ Tasigna (nilotinib)
☐ Votrient (pazopanib)
☐ Xeloda (capecitabine)
☐ Xtandi (enzalutamide)
☐ Zelboraf (vemurafenib)
☐ Zytiga (abiraterone)

RX 1: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 2: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

RX 3: Drug Name/Strength:_____

Sig:_____

Qty:_____ Refills:_____

Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____Date:_____**

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Please fax completed form to 1 855-595-2955