Publix Specialty Pharmacy #3 ORAL ONCOLOGY: MELANOMA/BASAL CE	19!	50 Sand Lake Road, Bldg 5 Orlando, FL 32809 Phone: 855-797-8254 Fax: 863-413-5723	
Patient Information         [Attach copy of front and back of prescript]			
Patient's First Name:	Patient's Last Name:		
Date of Birth:/	Caregiver Name:		
Address:	City:	_ State:	Zip:
Primary Phone Number: ()	Alt. Phone Number: (	)	
<b>Clinical Information</b> [Attach copy of labs and clinical notes]	□ Urgent Request	Using Cover 1	My Meds: 🗆 No 🗆 Yes
Diagnosis code: Diagnosis: 🗆 Malignant me	elanoma 🛛 Basal cell carcinoma	□ Other:	
Treatment status: $\Box$ New to therapy $\Box$ Continuation of therapy, s	start date:///	Height: _	$\_$ cm $\square$ in
BRAF mutations:  None V600K V600E Other:		Weight: _	$\_$ $\Box$ kg $\Box$ lb
Allergies:  NKDA Other:			
Prior therapies, treatment dates, and reason for discontinuation:			

Other pertinent past medical history and/or drug therapy:

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
Cotellic (cobimetinib)	20 mg tablet	Take 20 mg (1 tab) PO one time daily on days 1 through 21 on a 28-day cycle Take 40 mg (2 tabs) PO one time daily on days 1 through 21 on a 28-day cycle Take 60 mg (3 tabs) PO one time daily on days 1 through 21 on a 28-day cycle		
<ul> <li>Erivedge (vismodegib)</li> </ul>	150 mg capsule	Take 150 mg (1 cap) PO one time daily	28 days	
	□ 2 mg tablet	Take 2 mg (1 tab) PO one time daily at least 1 hour before and 2 hours after meal		
<ul> <li>Mekinist (trametinib)</li> </ul>	□ 0.5 mg tablet	<ul> <li>Take 1.5 mg (3 tabs) PO one time daily at least 1 hour before and 2 hours after meal</li> <li>Take 1 mg (2 tabs) PO one time daily at least 1 hour before and 2 hours after meal</li> </ul>	30 days	
□				
Prescriber Infor	mation Ship to p	prescriber:  Never Always First fill only Appointment date:	_//	
Name:		DEA# NPI #		

Supervising Physician:  Not Applicable	Superv	vising Physician NPI #		
Address:	City:	State:	Zip:	
Office Phone Number: ()	Fax Number: ()	Office Contact:		

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature:				For states requiring hand written expressions to prevent substitution, write here:
(stamps not accepted)	□ Substitution allowed	Date	Dispense as written/ Do not substitute Date	

This document, and any attachments, are intended solely for the use of the individual(s) to whom they are addressed. They may contain confidential information and/or protected health information (PHI) that is protected by law. If you believe you were not the intended recipient of this document, you are hereby notified that any review, dissemination, distribution, printing or copying of this document and/or any attachments is strictly prohibited. If you have received this transmission in error, please notify the sender immediately and destroy this document and any attachments. If you properly received this document, you should maintain its contents in confidence in accordance with applicable law. (07-22)

Publix Specialty Pharmacy # ORAL ONCOLOGY: MELANOMA/BASAL	1950 Sand Lake Road, Bldg Orlando, FL 32809 Phone: 855-797-8254 Fax: 863-413-5723		
Patient Information [Attach copy of front and back of presen	ription insurance card(s)]		
Patient's First Name:	Patient's Last Name:		
Date of Birth:/ □ Male □ Female	Caregiver Name:		
Address:	City:	State:	Zip:
Primary Phone Number: ()	Alt. Phone Number: ()		
Clinical Information [Attach copy of labs and clinical no	otes] 🛛 Urgent Request	Using Cover M	⁄ly Meds: □No □Yes
Diagnosis code: Diagnosis: 🗆 Malignant	melanoma 🛛 Basal cell carcinoma	□ Other:	
Treatment status: $\Box$ New to therapy $\Box$ Continuation of therap	y, start date:///	Height:	$\square$ cm $\square$ in
BRAF mutations:  None V600K V600E Other:		Weight:	$\_$ $\Box$ kg $\Box$ lb
Allergies:  NKDA Other:			
Prior therapies, treatment dates, and reason for discontinuation:			

Other pertinent past medical history and/or drug therapy: \_

MEDICATION	DOSE/ STRENGTH	DIRECTIONS		REFILLS	
<ul> <li>Odomzo (sonidegib)</li> </ul>	200 mg capsule	Take 200 mg (1 cap) PO one time daily at least 1 hour before and 2 hours after meal	30 days		
□ Tafinlar	□ 75 mg capsule	<ul> <li>Take 150 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal</li> <li>Take 75 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal</li> </ul>			
(dabrafenib)	□ 50 mg capsule □ Take 100 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal □ Take 50 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal		30 days		
□ Zelboraf (vemurafenib)	240 mg tablet	Take 960 mg (4 tabs) PO every 12 hours	28 days		
□					
Prescriber Information       Ship to prescriber: <ul> <li>Never</li> <li>Always</li> <li>First fill only</li> <li>Appointment date:/</li> </ul>					

Name:	DEA#	NPI #	
Supervising Physician: $\Box$ Not Applicable $\Box$		_ Supervising Physician NPI #	
Address:	City:	State:	Zip:
Office Phone Number: ()	_ Fax Number: ()	Office Contact:	
I authorize Publix Pharmacy representatives to act o	n behalf of the prescriber to initiate	e and complete the insurance prior auth	norization process.

Prescriber's signature:					For states requiring hand written expressions to prevent substitution, write here:
(stamps not accepted)	□ Substitution allowed	Date	Dispense as written/ Do not substitute	Date	

This document, and any attachments, are intended solely for the use of the individual(s) to whom they are addressed. They may contain confidential information and/or protected health information (PHI) that is protected by law. If you believe you were not the intended recipient of this document, you are hereby notified that any review, dissemination, distribution, printing or copying of this document and/or any attachments is strictly prohibited. If you have received this transmission in error, please notify the sender immediately and destroy this document and any attachments. If you properly received this document, you should maintain its contents in confidence in accordance with applicable law. (07-22)