Publix Specialty Pharmacy #3213

ORAL ONCOLOGY: MELANOMA/BASAL CELL CARCINOMA (FORM A)

1950 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 prescription 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 notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ Diagnosis: ☐Malignant melanoma ☐Basal cell carcinoma ☐Other: _____

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: _____/_____/_____ Height: _____☐cm ☐in

BRAF mutations:☐None ☐V600K ☐V600E ☐Other: _____ Weight: _____☐kg ☐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	28 days	_____
☐ Erivedge (vismodegib)	150 mg capsule	Take 150 mg (1 cap) PO one time daily	28 days	_____
☐ Mekinist (trametinib)	☐2 mg tablet	Take 2 mg (1 tab) PO one time daily at least 1 hour before and 2 hours after meal	30 days	_____
	☐0.5 mg tablet	☐ Take 1.5 mg (3 tabs) PO one time daily at least 1 hour before and 2 hours after meal ☐ Take 1 mg (2 tabs) PO one time daily at least 1 hour before and 2 hours after meal		
☐ _____	_____	_____	_____	_____

Prescriber Information

Ship to prescriber: ☐ Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable☐ _____ Supervising 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: (stamps not accepted) _____ ☐Substitution allowed Date _____ ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

Publix Specialty Pharmacy #3213

ORAL ONCOLOGY: MELANOMA/BASAL CELL CARCINOMA (FORM B)

1950 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 prescription 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 notes] ☐Urgent Request Using Cover My Meds: ☐No ☐Yes

Diagnosis code: _____ Diagnosis: ☐Malignant melanoma ☐Basal cell carcinoma ☐Other: _____

Treatment status: ☐New to therapy ☐Continuation of therapy, start date: _____/_____/_____ Height: _____☐cm ☐in

BRAF mutations:☐None ☐V600K ☐V600E ☐Other: _____ Weight: _____☐kg ☐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
☐ Odomzo (sonidegib)	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 (dabrafenib)	☐75 mg capsule	☐ Take 150 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal ☐ Take 75 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal	30 days	_____
	☐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		
☐ Zelboraf (vemurafenib)	240 mg tablet	Take 960 mg (4 tabs) PO every 12 hours	28 days	_____
☐ _____	_____	_____	_____	_____

Prescriber Information Ship to prescriber: ☐ Never ☐Always ☐First fill only Appointment date: _____/_____/_____

Name: _____ DEA# _____ NPI # _____

Supervising Physician: ☐ Not Applicable☐ _____ Supervising 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: (stamps not accepted) _____ ☐Substitution allowed Date _____ ☐Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here: