RARE SPECIALTY PHARMACY
@RareSpecialtyRx | RareSpecialtyRx.com | #RareSpecialtyRx

P: (855) 713-7049 | F: (888) 509-1154
398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

***(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)***

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

IDC-10 Diagnosis Code: ❑_____ Weight _____ BSA _____$m^2$ Biopsy? ❑Yes ❑No Results: _____
Patient currently on therapy? ❑ Yes ❑ No Date of next blood work _____
Current medications (including OTC) with dosage and direction (or fax)_____

# ONCOLOGY ORDER FORM

❑ **AFINITOR** tablets ❑ 2mg ❑ 2.5mg ❑ 5mg ❑ 7.5mg ❑ 10mg
❑ **ARIMIDEX** tablets ❑ 1mg
❑ **AROMASIN** tablets ❑ 25mg
❑ **GLEEVEC** tablets ❑ 100mg ❑ 400mg
❑ **HYCAMTIN** tablets ❑ 0.25mg ❑ 1mg
❑ **JAKAFI** tablets ❑ 5mg ❑ 10mg ❑ 15mg ❑ 20mg ❑ 25mg
❑ **KISQALI FCT** tablets ❑ 200mg ❑ 400mg ❑ 600mg
❑ **KISQALI FEMARA CO-PK** ❑ 200mg/2.5mg ❑ 400mg/2.5mg ❑ 600mg/2.5 mg
❑ **LEUKERAN** tablets ❑ 2mg
❑ **MATULANE** capsules ❑ 50mg
❑ **NEXAVAR** tablet ❑ 200mg
❑ **NINLARO** capsules ❑ 2.3mg ❑ 3mg ❑ 4mg
❑ **RYDAPT** capsules ❑ 25mg
❑ **SPRYCEL** tablets ❑ 20mg ❑ 50mg ❑ 70mg ❑ 80mg ❑ 100mg ❑ 140mg
❑ **STIVARGA** tablets ❑ 40mg
❑ **SUTENT** capsules ❑ 12.5mg ❑ 25mg ❑ 37.5mg ❑ 50mg
❑ **TAMOXIFEN** tablets ❑ 20mg
❑ **TARCEVA** tablets ❑ 25mg ❑ 100mg ❑ 150mg
❑ **TASIGNA** capsules ❑ 150mg ❑ 200mg
❑ **THALOMID** capsules ❑ 50mg ❑ 100mg ❑ 150mg ❑ 200mg
❑ **TYKERB** tablets ❑ 250mg
❑ **VOTRIENT** tablets ❑ 200mg
❑ **XELODA** tablets ❑ 150mg ❑ 500mg
❑ **XTANDI** capsules ❑ 40mg ❑ 80mg
❑ **ZOLINZA** capsules ❑ 100mg
❑ **ZYTIGA** tablets ❑ 250mg ❑ 500mg
SIG: QTY:_____ Refills: _____

❑ **ABRAXANE** Single Dose Vial ❑ 100mg
❑ **ALIMTA** Single Dose Vial ❑ 100mg ❑ 500mg
❑ **CYCLOPHOSPHAMIDE** Single Dose Vial ❑ 500mg ❑ 1g ❑ 2g
❑ **CYCLOPHOSPHAMIDE** Tablets ❑ 25mg ❑ 50mg
❑ **ERBITUX** Single Dose Vial ❑ 100mg/50mL ❑ 200 mg/100mL
❑ **FASLODEX** Syringes ❑ 250mg/5ml
❑ **JEVTANA** Kit ❑ 60mg/1.5ml
❑ **TARGRETIN** (bexarotene) ❑ 75mg capsules ❑ 1% Gel 60gm ❑ DAW-1
❑ **VELCADE** (bortezomib) Vial ❑ 3.5mg ❑ DAW-1
SIG: QTY:_____ Refills: _____

❑ **ETOPOSIDE** Solution ❑ 100mg/5mL ❑ 500mg/25mL ❑ 1g/50mL
❑ **ETOPOSIDE** Capsules ❑ 50mg
❑ **HERCEPTIN** ❑ 150mg vial
❑ **RITUXAN** ❑ 100mg/ 10mL vial ❑ 500mg/ 50mL vial
❑ **TEMODAR** Capsules ❑ 5mg ❑ 20mg ❑ 100mg ❑ 140mg ❑ 180mg ❑ 250mg
❑ **TEMODAR** Powder ❑ 100mg
SIG: QTY:_____ Refills: _____

❑ **JADENU** Tablets ❑ 90mg ❑ 180mg ❑ 360mg
SIG: QTY:_____ Refills: _____

❑ **KOATE** 1000 IU Vial
SIG: QTY:_____ Refills: _____

❑ **DARZALEX** SDV ❑ 100mg/5ml ❑ 400mg/20ml
❑ **EMPLICITI** SDV ❑ 300mg ❑ 400mg
SIG: QTY:_____ Refills: _____

❑ **KEYTRUDA** Single Dose Vial ❑ 100mg/4ml
❑ **OPDIVO** Single Dose Vial ❑ 40mg/4ml ❑ 100mg/10ml ❑ 240mg/24ml
SIG: QTY:_____ Refills: _____

❑ **ERIVEDGE** 150mg QTY: 28 REFILLS: _____
SIG: Take 1 capsule by mouth once daily.
❑ **ZELBORAF** 240mg QTY: 224 REFILLS: _____
SIG: Take 4 tablets by mouth twice daily approximately 12 hours apart with or without a meal.
❑ **COTELLIC** 20mg QTY: 63 REFILLS: _____
SIG: Take 3 tablets by mouth once daily for the first 21 days of each 28 day cycle.
❑ **AVASTIN** ❑ 100mg/SDV ❑ 400mg/SDV QTY: _____ REFILLS: _____
SIG: _____ mg IV every _____ weeks
❑ **LYNPARZA** ❑ 100mg ❑ 150mg QTY: _____ REFILLS: _____
SIG: Take _____ mg by mouth twice daily with or without food.
❑ **PIQRAY** ❑ 200mg ❑ 250mg ❑ 300mg QTY: _____ REFILLS: _____
SIG: Take _____mg by mouth once daily with food.
❑ **GAZYVA** 1000mg/40 ml SDV QTY: _____ REFILLS: _____
❑SIG: Chronic Lymphocytic Leukemia: IV infusion 100mg on day 1 and 900mg on day 2 of Cycle 1, 1,000mg on day 8 and 15 of Cycle 1, and 1,000mg on day 1 of Cycles 2–6
❑ **KADCYLA** ❑ 100mg SDV ❑ 160mg SDV QTY: _____ REFILLS: _____
SIG: 3.6mg/kg IV every 3 weeks for a total of 14 cycles in the absence of disease recurrence or unacceptable toxicity
❑ **PERJETA** 420mg SDV
❑ Initial 840mg administered as a 60-minute IV infusion QTY: _____ REFILLS: _____
❑ Maintenance: 420mg IV over 30-60 minutes every 3 weeks QTY: _____ REFILLS: _____
SIG: Initial 840mg administered as a 60-minute IV infusion, followed every 3 weeks thereafter by 420mg administered as a 30 to 60 minute intravenous infusion.
❑ **PHESGO** ❑ 600-600mg SDV ❑ 1200-600mg SDV
❑ **Initial:** 1,200mg pertuzumab, 600mg trastuzumab, and 30,000 units hyaluronidase administered subcutaneously in the thigh over approximately 8 minutes QTY: _____ REFILLS: _____
❑ **Maintenance:** Every 3 weeks, 600mg pertuzumab, 600mg trastuzumab, and 20,000 units hyaluronidase administered subcutaneously over approximately 5 minutes. QTY: _____ REFILLS: _____
❑ **POLIVY** 30mg SDV QTY: _____ REFILLS: _____
SIG: 1.8mg/kg as an IV infusion over 90 minutes every 21 days for 6 cycles in combination with bendamustine and a rituximab product. Subsequent infusions may be administered over 30 minutes if the previous infusion is tolerated.
❑ **TECENTRIQ** ❑ 840mg SDV ❑ 1200mg SDV QTY: _____ REFILLS: _____
SIG: _____ mg IV every _____ weeks

**OTHER:**_____ SIG:_____ QTY:____ Refills:_____

**This prescription will be filled generically unless the prescriber writes "DAW" here:** _____

Please list ancillary supplies if needed: _____

Prescriber Name/Practice:_____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____