2100 New Bern Ave,
Raleigh, NC 27610

Dermatology Oncology

Date: __________ Date needed: _________ Ship to: ☐ Patient ☐ 1st dose to MD ☐ All doses to MD

Prescriber information

Prescriber:		NPI:
Supervising physician:		NPI:
Address:		
Phone:	Fax:	
Office contact:		

Patient information

Name:	Sex: ☐ M ☐ F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight: Height:	Allergies:		
Primary language: ☐ English ☐ Spanish ☐ Other:	Needs interpreter: ☐ Yes ☐ No		

Please include copies of the patient's insurance card or local pharmacy information.

Medical information

Primary diagnosis:	ICD-10:	Date of diagnosis:	BSA:	Location(s):
Radiation: ☐ Yes ☐ No ☐ Not eligible	Dates:	Reason not eligible:		
Surgery: ☐ Yes ☐ No ☐ Not eligible	Dates:	Reason not eligible:		
Prior medications:	Length of treatment:		Reason for discontinuing:	

Prescription information

Drug	Strength	Directions	Qty	Refills
☐ Odomzo®	☐ 200 mg capsule	Take one tablet by mouth once daily at least one hour before or at least two hours after a meal	_____	_____
☐ Tafinlar®	☐ 50 mg capsules ☐ 75 mg capsules	Take 150 mg by mouth twice daily at least one hour before or at least two hours after a meal	_____	_____
☐ Mekinist®	☐ 2 mg tablet	Take one tablet by mouth once daily at least one hour before or at least two hours after a meal	_____	_____
☐ Other	____________________	________________________________	______	______

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

Stamp signature not allowed, physician attests this is his/her legal signature.

PHYSICIAN SIGNATURE REQUIRED

________________________________ ________________________________

Dispense as Written / Brand Medically Necessary **Substitution allowed**

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