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Phone: 423-307-5757
6900 Lenox Village Dr., Ste #14 Nashville, TN 37211
Phone: 615-864-8990

FountainRx

Oral Oncology

Please fax patient demographics with prescription order form to:

Toll-Free 1-844-621-5199

Patient Information:

Name:
Address:
City: State: Zip:
Phone: Alt Phone:
Email:
DOB: Height: Weight:
Gender: ☐ M ☐ F Caregiver:

Prescriber Information:

Name:
Address:
City: State: Zip:
Phone: Fax:
NPI: DEA:
Tax ID:
Office Contact: Phone:

CLINICAL INFORMATION: **Dx (ICD-10Code):** **Description:**

Drug Allergies:

PLEASE FAX COPIES: ☐ **Medical Card (Front and Back)** ☐ **Prescription Card (Front and Back)** ☐ **Clinical Notes**

☐ Abiraterone Acetate (Yonsa®, Zytiga®)	☐ Erlotinib (Tarceva®)	☐ Nilutamide (Nilandron®)
☐ **Alectinib (Alecensa®)**	☐ Etoposide (Toposar®)	☐ **Nilotinib (Tasigna®)**
☐ Alpelisib (Piqray®)	☐ Everolimus (Afinitor®)	☐ **Niraparib (Zejula®)**
☐ Anastrozole (Arimidex®)	☐ **Everolimus Soluble (Afinitor Disperz®)**	☐ **Pazopanib (Votrient®)**
☐ **Asciminib (Scemblix®)**	☐ Exemestane (Aromasin®)	☐ **Pomalidomide (Pomalyst®)**
☐ **Axitinib (Inlyta®)**	☐ **Fedratinib (Inrebic®)**	☐ **Pralsetinib (Gavreto®)**
☐ **Azacitidine (Onureg®, Vidaza®)**	☐ Hydroxyurea (Hydrea®)	☐ **Ribociclib (Kisqali®)**
☐ Bexarotene (Targretin®)	☐ Imatinib Mesylate (Gleevec®)	☐ **Sonidegib (Odomzo®)**
☐ Bicalutamide (Casodex®)	☐ **Ixazomib (Ninlaro®)**	☐ Sorafenib (Nexavar®)
☐ Capecitabine (Xeloda®)	☐ Lapatinib ditosylate (Tykerb®)	☐ Sunitinib Maleate (Sutent®)
☐ **Capmatinib (Tabrecta®)**	☐ Lenalidomide (Revlimid®)	☐ **Tamoxifen (Soltamox®)**
☐ **Ceritinib (Zykadia®)**	☐ Letrozole (Femara®)	☐ Temozolomide (Temodar®)
☐ Chlorambucil (Leukeran®)	☐ **Letrozole–Ribociclib (Kisqali+Femara Co-Pack®)**	☐ **Thalidomide (Thalomid®)**
☐ **Cobimetinib (Cotellic®)**	☐ Leucovorin Calcium	☐ **Topotecan (Hycamtin®)**
☐ **Dabrafenib (Tafinlar®)**	☐ **Lomustine (Gleostine®)**	☐ Toremifene (Fareston®)
☐ **Dasatinib (Sprycel®)**	☐ Melphalan (Alkeran®,Evomela®)	☐ **Trametinib (Mekinist®)**
☐ Deferasirox (Exjade®,Jadenu®)	☐ Mercaptopurine (Purixan®)	☐ Tretinoin Oral
☐ **Decitabine-Cedazuridine (Inqovi®)**	☐ **Mesna (Mesnex®)**	☐ **Vismodegib (Erivedge®)**
☐ **Enasidenib (IDHIFA®)**	☐ Methotrexate (Xatmep®)	☐ **Vemurafenib (Zelboraf®)**
☐ **Entrectinib (Rozlytrek®)**	☐ **Midostaurin (Rydapt®)**	☐ **Vorinostat (Zolinza®)**
☐ **Eltrombopag (Promacta®)**	☐ Mitoxantrone (Novantrone®)	☐ Other:

Patient New to Therapy: ☐ Yes ☐ No **Sample/Starter Provided:** ☐ Yes ☐ No (If Yes, provide start date):

Has Patient had Prior Treatment for this Diagnosis: ☐ Yes ☐ No If Yes, Date(s) of previous therapy and medication:

Desired Cycle Start Date: **Strength:** **Quantity:**

Directions: **Refills:**

By signing this form and utilizing our services, you are authorizing FountainRx and/or its designee to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and patient assistance programs. In addition, the pharmacy may substitute an appropriate generic equivalent in accordance with state law. My signature certifies that the person named on this form is my patient, the information provided on this application, to the best of my knowledge, is complete and accurate and the therapy identified is medically necessary.

Physician Signature: **Date:**