




CareMed

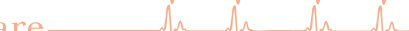
Pharmaceutical Services


Phone: 516.355.2273


Fax: 516.326.2273


OncoCare Prescription Form

NeuroCare 

ImmunoCare 

HemaCare 

RheumaCare 

HepaCare 

Patient Information

Last Name	First Name	SSN	DOB
Home Address	City	State	Zip
Home Phone	Work Phone	Parent/Guardian	
Shipping Address	City	State	Zip
Other Pertinent Information			

Delivery Information

Today's Date:	Date & Time Needed:	Deliver to:
		<input type="checkbox"/> Patient's Home <input type="checkbox"/> MD Office/Clinic <input type="checkbox"/> Patient's Work <input type="checkbox"/> Other: _____

Pharmacy Insurance Information

Primary Insurance:	Rx Bin:
ID Number:	Group Number:
Secondary Insurance:	Rx Bin:
ID Number:	Group Number:

Medications (You may tape Prescription here prior to faxing)

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Xeloda ®				
<input type="checkbox"/> Nexavar ®				
<input type="checkbox"/> Sprycel ®				
<input type="checkbox"/> Gleevec ®				
<input type="checkbox"/> Tarceva ®				
<input type="checkbox"/> Sutent ®				
<input type="checkbox"/> Zolinza ®				
<input type="checkbox"/> Matulane ®				
<input type="checkbox"/> Thalomid ®				0
<input type="checkbox"/> Revlimid ®				0
<input type="checkbox"/> Tykerb ®				
Others:				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Physician Information

Prescriber Name:	DEA:		
Licence:	Office Contact:		
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Diagnoses Information

Primary Dx	ICD-9
Secondary Dx	ICD-9
Tertiary Dx	ICD-9

Revlimid Required Information

<input type="checkbox"/> Adult Female - NOT of Childbearing Potential <input type="checkbox"/> Adult Female - Childbearing Potential <input type="checkbox"/> Adult Male <input type="checkbox"/> Female Child - NOT of Childbearing Potential <input type="checkbox"/> Female Child - Childbearing Potential <input type="checkbox"/> Male Child
--

Celgene® Authorization Number *Required for Revlimid® & Thalomid®
--

PRESCRIBER'S SIGNATURE REQUIRED

MD / NP / PA Signature: _____
