Physician Request Form for Oral Oncology Medications
Fax to PerformRx at **855-811-9332**, or to speak to a Representative call **888-602-3741**. ***Form must be completed for processing.***

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID#: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Height: _____ Weight: _____lbs = _____Kg BSA = _____ Birth Date: _____

Physician Name: _____ NPI #: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____ Phone #: _____ Fax #: _____

IMPORTANT NOTE: Please include a copy of the actual prescription with the each request. Failure to do so may result in a delay in the medication being shipped to the patient.

Please check the box of the medication you are requesting:

❑ Aromasin®	❑ Sutent®	❑ Tykerb®
❑ Arimidex®	❑ Tarceva®	❑ Vesanoid®
❑ Gleevec®	❑ Targretin®	❑ Other:
❑ Nexavar®	❑ Tasigna®	
❑ Revlimid®	❑ Temodar®	
❑ Sprycel®	❑ Thalomid®	

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Dose: _____ Sig (How Administered): _____ Refills: _____

Please complete all applicable sections:

For Revlimid® Requests:
- Is the patient registered with and meet all of the requirements of the REVASSIST™ Program? ❑ **Yes** ❑ **No**
- *For patients with myelodysplastic syndrome only.*
  - Hemoglobin level = _____g/dl date of lab _____

For Tarceva® Requests:
- Does the patient have a documented trial and failure with a previous chemotherapy regimen? ❑ **Yes** ❑ **No**
- What is the patient's Eastern Cooperative Oncology Group (ECOG) Performance Status _____

For Gleevec® Requests:
- For patients who require a dose of **greater than 600 mg/day** for the treatment of chromic myelogenous leukemia (CML) only:
  - Did the patient lack a hematologic response, lack a cytogenetic response, or relapsed after a hematologic response while receiving a dose of 600 mg/d or less? ❑ **Yes** ❑ **No**
  - Does the patient have a documented trial and failure with Sprycel® (dasatinib) or Tasigna® (nilotinib)? ❑ **Yes** ❑ **No**

For Tasigna® Requests:
- Potassium level = _____ mEq/L date of lab
- Magnesium level = _____ mEq/L date of lab
- Does the patient have a diagnosis of long QT syndrome? ❑ **Yes** ❑ **No** date of electrocardiogram (ECG) _____
- Does the patient have a documented trial and failure with Gleevec® (imatinib)? ❑ **Yes** ❑ **No**

For Tykerb® Requests:
- Does the patient have human epidermal receptor type 2 (HER2) positive breast cancer? ❑ **Yes** ❑ **No**
- Does the patient have a documented trial and failure with a previous chemotherapy regimen that includes an anthracycline, a taxane and Herceptin® (trastuzumab)? ❑ **Yes** ❑ **No**
- Is the medication being used concurrently with Xeloda® (capecitabine)? ❑ **Yes** ❑ **No**

For Nexavar® and Sutent® Requests:
- KIDNEY CANCER - Does the patient have a Stage I-III tumor that has relapsed after surgical intervention OR an unresectable tumor OR a Stage IV tumor? ❑ **Yes** ❑ **No**
- FOR NEXAVAR ONLY: For patients with Hepatocellular carcinoma:
  - The patients Child-Pugh Class = _____
  - Is the patient not a suitable candidate for a liver transplant, has a medically/surgically unresectable tumor or has declined the surgery? ❑ **Yes** ❑ **No**
- FOR SUTENT ONLY: For patients with gastrointestinal stromal tumor (GIST):
  - Does the patient have a documented trial and failure with Gleevec® (imatinib)? ❑ **Yes** ❑ **No**

If you answered "NO" to any question please explain (please include attachments if necessary): _____

If the medication is being used for a dosage which is above the FDA approved dosing guidelines OR for a diagnosis other than a FDA approved indication please include all applicable documentation and the rationale behind using this treatment (please include attachments if necessary): _____

Prescriber Signature: _____ **Date:** _____

PERFORMRX