BioPlus® Specialty Pharmacy

A Carelon Company

Medicare Part B Oncology

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com/therapy

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Primary Diagnosis	ICD-10	Secondary Diagnosis	ICD-10
Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Metastatic Disease: ☐ No ☐ Yes	HER2: ☐ Positive ☐ Negative
BSA m2	Hormone Receptor: ☐ ER Positive ☐ ER Negative ☐ PR Positive ☐ PR Negative	Treatment Status: ☐ New to Therapy ☐ Continuation of Therapy, Start Date: _____ / _____ / _____	
Prior Therapy		Length of Treatment	Reason for Discontinuing
Allergies: ☐ NKDA ☐ Other: _____			Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

Must Include Dose/Frequency/Cycle On and Off Days

			Qty	Refills
☐ Xeloda®	☐ 150 mg Tablet ☐ 500 mg Tablet	☐ Take _____ mg by mouth every 12 hours for 14 days on, then 7 days off ☐ Conjunction with radiation: Take _____ mg by mouth every 12 hours with radiation for _____ days a week for a total of _____ weeks ☐ Other: _____	____ 150 mg Tablet(s) ____ 500 mg Tablet(s)	_____ _____
☐ Temodar®	☐ 5 mg Capsule ☐ 20 mg Capsule ☐ 100 mg Capsule ☐ 140 mg Capsule ☐ 180 mg Capsule ☐ 250 mg Capsule	☐ Take _____ mg by mouth once daily for 5 days on, then 23 days off ☐ Conjunction with radiation: Take _____ mg by mouth once daily with radiation for _____ days a week for a total of _____ weeks ☐ Other: _____	____ 5 mg Capsule(s) ____ 20 mg Capsule(s) ____ 100 mg Capsule(s) ____ 140 mg Capsule(s) ____ 180 mg Capsule(s) ____ 250 mg Capsule(s)	_____ _____ _____ _____ _____ _____
☐ Other Drug Name: _____ _____ _____	Strength/Formulation: _____ _____ _____	Include Dose/Frequency/Cycle On and Off Days: _____ _____ _____	_____ _____ _____	_____ _____ _____

_____ _____ _____ _____

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**