Biologics

McKesson Specialty Health

Ovarian Cancer Prescription Referral Form

Fax: 800.823.4506 Phone: 800.850.4306, option 2

To ensure your patient receives his/her medication as soon as possible, please complete and fax this form, with the patient's relevant treatment history and clinic notes to support the prior authorization process.

☐ **Contact Prescriber with results of benefits investigation before initiating dispense or contacting patient.**

PATIENT INFORMATION

Full Name_____ Gender ☐ M ☐ F DOB_____ Social Security #_____

Shipping Address_____ City_____ State_____ Zip_____

Home Phone_____ Alternate Phone_____

Alternate Contact_____ Relationship_____

Alternate Contact Phone_____ **Oncology Care Model Patient** ☐ YES ☐ NO

INSURANCE INFORMATION

Please include a copy of the front and back of the patient's medical and prescription insurance cards.

CLINICAL INFORMATION

ICD-10 Code_____ Primary Diagnosis/Stage_____

Height_____ Weight_____ Allergies_____

Prior Therapies_____

_____

Reasons for Discontinuation_____ Year_____

Is patient receiving oral steroids? ☐ YES ☐ NO If yes, give dose/duration: Prednisone_____ Dexamethasone_____

Notes_____

List other medications that are being administered as part of this chemotherapy regimen including dose and duration.

_____

PRESCRIBER INFORMATION

Hospital/Clinic_____ Office Contact_____

Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Tax ID_____

Prescriber Names	DEA #	NPI #
☐		
☐		
☐		
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PRESCRIPTION INFORMATION

Rx Start Date_____ **Rx Sent Via** ☐ fax ☐ escribe

Date of last dose of platinum therapy (please attach documentation): _____

Previously tried and failed therapies:_____

Medication	Directions	Quantity	Refills
☐ LYNPARZA (olaparib)*	☐ 400 mg twice daily	☐ 50 mg capsules** x _____	
	☐ 300 mg twice daily	☐ 100 mg tablets x _____	
	☐ Other: _____	☐ 150 mg tablets x _____	_____
☐ RUBRACA (rucaparib)	☐ 600 mg twice daily	☐ 200 mg tablets x _____	
	☐ Other: _____	☐ 250 mg tablets x _____	
		☐ 300 mg tablets x _____	_____
☐ ZEJULA (niraparib)	☐ 300 mg once daily	☐ 100 mg capsules x _____	
	☐ Other: _____		_____
☐ Other: _____	☐ _____	☐ _____ x _____	_____

*Please note: Tablet and capsule dosing for Lynparza are **not equivalent**. Please contact Biologics with any questions or visit www.lynparzahcp.com for more details.
**Please note: After September 1, 2018, Lynparza capsules will no longer be available.

Prescriber Signature (No Stamps)_____ **Date**_____

Please attach a separate prescription if this form does not comply with your state's prescription law.

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