

Feeling well. Living better.

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: _____ Patient's Last Name: _____ Date of Birth: ___/___/___ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone Number: (____) _____ Alt. Phone Number: (____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: _____ Diagnosis: Malignant melanoma Basal cell carcinoma Other: _____
 Treatment status: New to therapy Continuation of therapy, start date: ___/___/___ BRAF mutations: None V600K V600E Other: _____
 Weight: ___ kg lb Height: ___ cm in Allergies: NKDA Other: _____
 Prior therapies, reason for discontinuation, treatment dates: _____
 Other pertinent past medical history and/or drug therapy: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
<input type="checkbox"/> Mekinist (trametinib)	<input type="checkbox"/> 2 mg tablet	<input type="checkbox"/> Take 2 mg (1 tab) PO once daily at least 1 hour before and 2 hours after meal <input type="checkbox"/> Other: _____	30 days	_____
	<input type="checkbox"/> 0.5 mg tablet	<input type="checkbox"/> Take 1.5 mg (3 tabs) PO once daily at least 1 hour before and 2 hours after meal <input type="checkbox"/> Take 1 mg (2 tabs) PO once daily at least 1 hour before and 2 hours after meal <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Tafinlar (dabrafenib)	<input type="checkbox"/> 75 mg capsule	<input type="checkbox"/> Take 150 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal <input type="checkbox"/> Take 75 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal <input type="checkbox"/> Other: _____	30 days	_____
	<input type="checkbox"/> 50 mg capsule	<input type="checkbox"/> Take 100 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal <input type="checkbox"/> Take 50 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Odomzo (sonidegib)	200 mg capsule	<input type="checkbox"/> Take 200 mg (1 cap) PO once daily at least 1 hour before and 2 hours after meal <input type="checkbox"/> Other: _____	30 days	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____	_____

Prescriber Information [Ship to prescriber: Never Always First fill only, appointment date: ___/___/___] Use Cover My Meds: No Yes

Name: _____ DEA# _____ NPI # _____
 Address: _____ City: _____ State: _____ Zip: _____
 Office Phone Number: (____) _____ Fax Number: (____) _____ Office Contact: _____

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: _____ Date _____
 (stamps not accepted) Substitution allowed Dispense as written/ Do not substitute

For states requiring hand written expressions to prevent substitution, write here:

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