PUBLIX PHARMACY

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Oral Oncology Referral Form: Melanoma/ Basal Cell Carcinoma

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

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
☐ Mekinist (trametinib)	☐ 2 mg tablet	☐ Take 2 mg (1 tab) PO once daily at least 1 hour before and 2 hours after meal ☐ Other: _____	30 days	_____
	☐ 0.5 mg tablet	☐ Take 1.5 mg (3 tabs) PO once daily at least 1 hour before and 2 hours after meal ☐ Take 1 mg (2 tabs) PO once daily at least 1 hour before and 2 hours after meal ☐ Other: _____		
☐ Tafinlar (dabrafenib)	☐ 75 mg capsule	☐ Take 150 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal ☐ Take 75 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal ☐ Other: _____	30 days	_____
	☐ 50 mg capsule	☐ Take 100 mg (2 caps) PO Q12H at least 1 hour before and 2 hours after meal ☐ Take 50 mg (1 cap) PO Q12H at least 1 hour before and 2 hours after meal ☐ Other: _____		
☐ Odomzo (sonidegib)	200 mg capsule	☐ Take 200 mg (1 cap) PO once daily at least 1 hour before and 2 hours after meal ☐ Other: _____	30 days	_____
☐ Other: _____	_____	_____	_____	_____
☐ 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: (stamps not accepted)

_____ ☐ Substitution allowed Date

_____ ☐ Dispense as written/ Do not substitute Date

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