

• (P) 973.925.7200

• www.BarnertPharmacy.com

• (F) 973.925.7202

Patient information		Prescriber information	
Name:	DOB:	Prescriber's Name:	
Address: City, State, Zip		NPI#	
		DEA#	License#
Phone #	Alt#	Address City, State, Zip	
SSN:			
Height:	Wt:	Phone #	Fax #
Allergies:		Contact Person:	
Emergency Contact/ Phone #		Delivery: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient Home	

Clinical Considerations
Diagnosis (ICD 10) : _____

Oral Drugs	Prescribing Information
<input type="checkbox"/> Afinitor® <input type="checkbox"/> Jadenu® <input type="checkbox"/> Rydapt® <input type="checkbox"/> Tykerb® <input type="checkbox"/> Arimidex® <input type="checkbox"/> Kisqali® <input type="checkbox"/> Sprycel® <input type="checkbox"/> Votrient® <input type="checkbox"/> Aromasin® <input type="checkbox"/> Mekinist® <input type="checkbox"/> Tafenlar® <input type="checkbox"/> Xeloda® <input type="checkbox"/> Farydak® <input type="checkbox"/> Ninlaro® <input type="checkbox"/> Tamoxifen® <input type="checkbox"/> Zolozina® <input type="checkbox"/> Femara® <input type="checkbox"/> Noxafil® <input type="checkbox"/> Tassigna® <input type="checkbox"/> Zykadia® <input type="checkbox"/> Gleevec® <input type="checkbox"/> Odomzo® <input type="checkbox"/> Temodar® <input type="checkbox"/> Zytiga® <input type="checkbox"/> Hycamtin®	<input type="checkbox"/> Strength: <input type="checkbox"/> Quantity: <input type="checkbox"/> Refills: <input type="checkbox"/> SIG:
<input type="checkbox"/> Other:	
Injectable Drugs	Prescribing Information
<input type="checkbox"/> Aranesp® <input type="checkbox"/> Granix <input type="checkbox"/> Neulasta® <input type="checkbox"/> Prolia® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Leukine® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Sandostatin® <input type="checkbox"/> Folutyn® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Pegasys® <input type="checkbox"/> Sylatron® <input type="checkbox"/> Fragmin® <input type="checkbox"/> Lupron® <input type="checkbox"/> Procrit® <input type="checkbox"/> Zaxio® <input type="checkbox"/> Other: <input type="checkbox"/> Zometa	<input type="checkbox"/> Strength: <input type="checkbox"/> Quantity: <input type="checkbox"/> Refills: <input type="checkbox"/> SIG:
IV Infusion Drugs	Prescribing Information
<input type="checkbox"/> Abraxane® <input type="checkbox"/> Carboplatin® <input type="checkbox"/> Gemzar® <input type="checkbox"/> 5 FU <input type="checkbox"/> Alimta® <input type="checkbox"/> Dacarbazine® <input type="checkbox"/> Keytruda® <input type="checkbox"/> Vidaza <input type="checkbox"/> Bleomycin® <input type="checkbox"/> Erbitux® <input type="checkbox"/> Taxotere® <input type="checkbox"/> Vinblastine <input type="checkbox"/> Cyclophosphamide <input type="checkbox"/> Doxorubicin <input type="checkbox"/> Velcade <input type="checkbox"/> Other	<input type="checkbox"/> Strength: <input type="checkbox"/> Quantity: <input type="checkbox"/> Refills: <input type="checkbox"/> SIG:
Supportive Drugs	Prescribing Information
<input type="checkbox"/> Emend® <input type="checkbox"/> NS Flush <input type="checkbox"/> Sancuso® <input type="checkbox"/> Heparin Flush <input type="checkbox"/> Promacta® <input type="checkbox"/> Zofran® <input type="checkbox"/> Other:	<input type="checkbox"/> Strength: <input type="checkbox"/> Quantity: <input type="checkbox"/> Refills: <input type="checkbox"/> SIG:

By signing this form I authorize Barnert Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

____ **Prescriber's signature** (no stamps) if brand required check this DAW____

Date