Antineoplastics and Adjunctive Therapies – Tyrosine Kinase Inhibitors - Oral

Please provide the information below, please print your answers, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.
Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3.

Date of Request			
Patient	Date of Birth	Molina ID	
Pharmacy Name	Pharmacy NPI	Telephone Number	Fax Number
Prescriber	Prescriber NPI	Telephone Number	Fax Number
Medication and Strength	Directions for Use	Qty/Days Supply	

1. What is the patient's diagnosis (ICD code plus description)?

   Indicate stage:

   Indicate disease type:

2. Is patient currently being treated with this medication? ☐ Yes ☐ No
   If yes:
   When was treatment with the requested dose started?

   What measures were used to define positive clinical response?

   What is the change from baseline?

3. Will this medication be used in combination with other chemotherapeutic or adjuvant agents?

   If yes, list all therapies:

4. What is the patient's planned dosing regimen?

5. List treatments patient has previously tried and dates these treatments were started?

   How long were they on these treatments?

   Why were they discontinued?

6. Has diagnosis and disease mutation been confirmed with an FDA approved companion diagnostic test? ☐ Yes ☐ No ☐ Not applicable

7. Does the patient have a contraindication to the requested oral oncology medication regimen? ☐ Yes ☐ No If yes, indicate contraindication(s):		
8. Indicate if prescribed by or in consultation with: ☐ Hematologist ☐ Oncologist ☐ Other. Specify:		
9. Indicate for the patient: Height (cm): Date taken: Weight (kg): Date taken: Body surface area (m2): Date taken:		
CHART NOTES, LABS AND TEST RESULTS, INCLUDING ALL DIAGNOSTIC TESTS, ARE REQUIRED WITH THIS REQUEST		
Prescriber Signature	Prescriber Specialty	Date

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