

Four simple steps to submit your referral.

1 PATIENT INFORMATION New patient Current

Patient's name _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____ Cell phone _____
 Evening phone _____ E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____ Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____ Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 The patient has tested positive for EGFR mutation: Yes No
 The patient has squamous histology: Yes No
 Current weight _____ kg/lbs Date wt obtained _____
 NKDA Known drug allergies _____

 Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation	Directions	Quantity/Refills
Gilotrif® (afatinib)	<input type="checkbox"/> 40 mg tablet <input type="checkbox"/> 30 mg tablet <input type="checkbox"/> 20 mg tablet	<input type="checkbox"/> Take _____ tablet(s) daily. <input type="checkbox"/> Other _____	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

By your acknowledgement and signature above, an authorization is provided to dispense the prescription as written including a patient welcome kit with an associated supply of loperamide.

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Please fax completed form to your drug therapy team at 888.454.8488.
 To reach your team, call toll-free 844.569.2836.

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 ONC-00053-041017 amc5670