Genefic
SPECIALTY PHARMACY

To expedite processing, please send the following information with prescription.

- ☐ Referral Form
- ☐ Demographic Sheet
- ☐ Most Recent Clinical Notes
- ☐ List of Tried and Failed Meds (Including other Biologics)
- ☐ Prescription Insurance Card (Front & Back)

Bio-Coordinator or Primary Point of Contact at Clinic:

Name: _____

Email: _____

Direct Phone Line: _____

Cell (optional, but preferred): _____

Genefic Specialty Pharmacy
2577 Mall Road, Suite B
Florence, AL, 35630

Phone: (833) 928-7660
Fax: (833) 928-7661
Website: GeneficRx.com

Faxed prescriptions will only be accepted from a prescriber. Patients must bring an original prescription to the pharmacy, and cannot fax these referral forms to Genefic Specialty Pharmacy.

Dermatologic Oncology Enrollment Form

Prescriber:	**NPI:**
Supervising Physician:	**NPI:**
Address:	**Tax ID:**
Phone:	Fax:
Contact:	

PATIENT INFORMATION

Name:	☐ M ☐ F ☐ Trans M ☐ Trans F ☐ Other	DOB: ____/____/_____	SS#: ____-____-_____
Street:	City:	State:	ZIP:
Phone:	Alt. Phone:	☐ English ☐ Spanish ☐ Other: _____	Wt.: Ht.:

PRESCRIPTION

☐ **New** ☐**Refill** **Ship by:** ____/____/_____ **SHIP TO:** ☐ **Patient's Home** ☐ **Doctor's Office** ☐ **Other:** _____

Drug		Directions & Quantity	Refills
Erivedge®	☐ 150 mg Capsules	☐ Take 150 mg once daily by mouth (Quantity: 28)	
Odomzo®	☐ 200 mg Capsules	☐ Take 200 mg once daily by mouth on an empty stomach, at least 1 hour before or 2 hours after a meal (Quantity: 30)	
Targretin® *(bexarotene)*	☐ 75 mg Capsules **BSA Required:** _____m^2	☐ Take _____ mg by mouth once daily with food (Quantity: QS 30 days) ***RECOMMENDED DOSING*** 300 mg/m^2/day-taken as one daily dose	
Targretin®	☐1% Gel 60 gm	**INITIAL:** Quantity: 1 tube ☐ Week 1: Apply to affected area(s) once every **other** day as directed ☐ Week 2: Apply to affected area(s) once daily as directed ☐ Week 3: Apply to affected area(s) twice daily as directed ☐ Week 4: Apply to affected area(s) three times daily as directed ☐ Week 5: Apply to affected area(s) four times daily as directed **MAINTENANCE:** ☐ Apply to affected area(s) _____ times daily as directed (Quantity: 1 tube)	

MEDICAL INFORMATION

PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Reason(s) for Discontinuing:
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____
☐ _____	☐(_____)	☐	_____

Erivedge®

Please specify patient as: ☐locally advanced disease ☐metastatic disease

☐ Patient has basal cell carcinoma that has recurred following surgery

☐ Patient has basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Odomzo®

☐ Patient has locally advanced basal cell carcinoma that has recurred following surgery

☐ Patient has locally advanced basal cell carcinoma and is *not* a candidate for surgery and *not* a candidate for radiation

Date of Diagnosis: _____/_____/_____

☐ **C44.91** Basal cell carcinoma, unspecified

☐ **C84.A0** Cutaneous T-cell lymphoma, unspecified, unspecified site

☐ **C44.____** _____

☐ **C84.A___** Cutaneous T-cell lymphoma, unspecified, _____

☐ **Other:** _____

Allergies:

Additional Clinical Information:

PRESCRIBER SIGNATURE REQUIRED---STAMPED SIGNATURE NOT ALLOWED

To Prescriber: By signing this form and utilizing our services, you are also authorizing Genefic Specialty Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

PRODUCT SUBSTITUTION PERMITTED	DISPENSE AS WRITTEN
X _____ Date: ____/____/_____	X _____ Date: ____/____/_____

CONFIDENTIALITY NOTICE