Onco360® ONCOLOGY PHARMACY

e-Prescribe: Oncomed Dba Onco360 or NPI #1679618151
Fax: 877.662.6355 | **Call:** 877.662.6633

Note: Onco360 only accepts prescription drug orders from qualifying prescribers.

Revlimid® - Thalomid® - Pomalyst® Oral Oncology Rx Order Form

Patient Information (REQUIRED)

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: ❑ M ❑ F Last 4 Digits of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Email: _____

Patient Weight: _____lbs Patient Height: _____ Date Taken: _____ Allergies: _____

Pharmacy Benefit Manager (REQUIRED) *Please provide copies of both sides of the patient's card*

PBM Name: _____ Rx BIN#: _____ PCN#: _____

Rx Group#: _____ Member ID#: _____

Medical/Health Insurance Info. (REQUIRED) *Please provide copies of both sides of the patient's card*

Primary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary: _____ Policy Holder: _____ Policy # _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

Prior Therapy Type:

❑ Velcade ❑ Cyclophosphamide ❑ Thalomid ❑ Revlimid ❑ Other _____

Clinical/Prescription information

❑ LenalidomideREMS™ ❑ ThalomidREMS™ ❑ PomalystREMS™

Physician Authorization#: _____ Date: _____

Pharmacy Confirmation#: _____ Date: _____

Patient Risk Category

❑ Adult Female - NOT of Reproductive Potential
❑ Adult Female - Reproductive Potential
❑ Adult Male
❑ Female Child - NOT of Reproductive Potential
❑ Female Child - Reproductive Potential
❑ Male Child

Rx Prescription

Oral Medication	Available Strengths (please check)						Directions	Quantity	Blister Pack
Revlimid®	❑ 2.5mg	❑ 5mg	❑ 10mg	❑ 15mg	❑ 20mg	❑ 25mg			❑ yes ❑ no
Dexamethasone	❑ 4mg								❑ yes ❑ no
Thalomid®	❑ 50mg	❑ 100mg	❑ 150mg	❑ 200mg					
Dexamethasone	❑ 4mg								❑ yes ❑ no
Pomalyst®	❑ 1mg	❑ 2mg	❑ 3mg	❑ 4mg					❑ yes ❑ no
Ninlaro®	❑ 2.3mg	❑ 3mg	❑ 4mg						
Empliciti™									
Velcade®									

Diagnosis Information

Primary Dx: _____ Dx Date (needed for funding): _____ ICD-9/10: _____

Secondary Dx: _____ Dx Date (needed for funding): _____ ICD-9/10: _____

Physician Information

Prescriber name: _____ Contact: _____

Email: _____ Street: _____ City: _____

State: _____ Zip: _____ Ph: _____ Fax: _____ NPI #: _____

Tax ID # (*needed for funding*): _____ Prescriber Signature (required by law): _____ Date: _____

Prescription will be filled with generic unless prescriber writes "DAW" (dispense as written) in the box ☐

Shipping Instructions

Ship to: ❑ Physician's Office ❑ Patient's Home ❑ Other _____ Date Required: _____