



Fax the completed form to
(818) 236-2504

Questions? Call (818) 236-2500
Monday to Friday, 10 am to 6 pm

E-prescribing? Send to Foothill Remedy Drugs
6253 Foothill Blvd, Tujunga, CA 91042 · NPI 1134270135

Please send with this form: ☐ Insurance cards, front and back ☐ Recent labs ☐ Clinical notes ☐ Current medication list

1 Patient

Or attach a patient face sheet

Last name _____ First name _____ Date of birth _____

Sex ☐ F ☐ M ☐ X Height _____ Weight _____ ☐ kg ☐ lb Allergies ☐ None known _____

Address _____ City _____ State _____ ZIP _____

Cell phone _____ Other phone _____ Email _____

Preferred language ☐ English ☐ Armenian ☐ Farsi ☐ Russian ☐ Spanish ☐ Other _____

2 Insurance

Or attach copies of the cards, front and back

Primary plan _____ Member ID _____ Group # _____ Phone _____

Secondary plan _____ Member ID _____ Group # _____ Phone _____

3 Prescriber

Prescriber name _____ NPI _____ License # _____

Practice _____ Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Office contact _____

Contact phone _____ Contact email _____

4 Clinical information

Please attach recent labs and notes

Cancer type _____ ICD-10 _____ Stage _____

Supportive-care diagnosis ☐ D70.1 Neutropenia from chemo ☐ D64.81 Anemia from chemo ☐ D63.0 Anemia in cancer
☐ R11.2 Nausea with vomiting ☐ Other _____

Chemotherapy regimen _____ Cycle length _____ days Next cycle _____

ANC _____ Hemoglobin _____ Platelets _____ Creatinine _____ Lab date _____

Therapy status ☐ New start ☐ Continuing current therapy ☐ Switching from _____

Current medications ☐ List attached _____

5 Delivery

Needed by _____ Deliver to ☐ Patient's home ☐ Prescriber's office ☐ Patient will pick up at the pharmacy

Delivery is free within 25 miles of our Tujunga store.

Patient name _____ Date of birth _____

6 Prescription

Check each medication to fill. Directions and quantity can be changed.

☐ **New start: also dispense the loading doses in each checked drug's label**

Medication	Strength	Directions	Quantity	Refills
Blood count support				
☐ Pegfilgrastim Neulasta or the plan's preferred biosimilar	6 mg/0.6 mL syringe	Inject 6 mg subcut per cycle, 24+ hours after chemo	1 syringe	_____
☐ Rolvedon eflapregastim-xnst	13.2 mg/0.6 mL syringe	Inject 13.2 mg subcut per cycle, 24+ hours after chemo	1 syringe	_____
☐ Filgrastim Neupogen or the plan's preferred biosimilar	300 or 480 mcg syringe	Inject ____ mcg subcut once daily for ____ days	____ syringes	_____
☐ Epoetin alfa Retacrit, Procrit or Epogen	10,000 to 40,000 units/mL	Inject ____ units subcut once weekly	4 vials	_____
☐ Aranesp darbepoetin alfa	100 to 500 mcg syringe	Inject ____ mcg subcut every ____ weeks	1 syringe	_____
Hormone and bone therapy, given in the office				
☐ Lupron Depot leuprolide acetate	7.5, 22.5, 30 or 45 mg	Inject ____ mg into the muscle every ____ months	1 kit	_____
☐ Eligard leuprolide acetate	7.5, 22.5, 30 or 45 mg	Inject ____ mg subcut every ____ months	1 kit	_____
☐ Firmagon degarelix	80 mg or 120 mg vial	Inject 80 mg subcut every 28 days after 240 mg start	1 kit	_____
☐ Zoladex goserelin implant	3.6 mg or 10.8 mg	Implant ____ mg subcut every ____ weeks	1 implant	_____
☐ Fulvestrant generic	250 mg/5 mL syringe	Inject 500 mg (2 syringes) into the muscle monthly	2 syringes	_____
☐ Xgeva denosumab 120 mg, or the plan's preferred biosimilar	120 mg/1.7 mL vial	Inject 120 mg subcut every 4 weeks	1 vial	_____
☐ Octreotide Sandostatin or generic	50, 100 or 500 mcg/mL	Inject ____ mcg subcut ____ times daily	30-day supply	_____
☐ Sandostatin LAR octreotide depot	10, 20 or 30 mg kit	Inject ____ mg into the muscle every 4 weeks	1 kit	_____
☐ Lanreotide generic	120 mg syringe	Inject 120 mg deep subcut every 4 weeks	1 syringe	_____
Nausea and vomiting				
☐ Aprepitant Emend generic, 3-day pack	125 mg and 80 mg	125 mg 1 hr before chemo day 1; 80 mg days 2 and 3	1 pack	_____
☐ Ondansetron Zofran generic, tablet or ODT	4 mg or 8 mg	Take 8 mg by mouth every 8 hours as needed	30 tablets	_____
☐ Olanzapine Zyprexa generic	5 mg or 10 mg tablet	Take ____ mg by mouth at bedtime on days 1 to 4	____ tablets	_____
☐ Prochlorperazine Compazine generic	10 mg tablet	Take 1 tablet by mouth every 6 hours as needed	30 tablets	_____
☐ Dexamethasone generic	4 mg tablet	Take ____ mg by mouth _____	____ tablets	_____
Other medication (write in)				
☐ _____	_____	_____	_____	_____
☐ _____	_____	_____	_____	_____

7 Prescriber signature

By signing, I confirm that this medication is medically necessary and that the information on this form is accurate to the best of my knowledge.

Prescriber signature _____ Date _____

☐ Do not substitute Prescriber initials _____ California law requires the prescriber to initial this box to prevent substitution.