



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 _____

Biomarkers or mutations _____

Line of therapy ☐ First ☐ Second ☐ Third or later Given with ☐ Radiation ☐ Infusions or injections _____

Treatment start date _____ Body surface area _____ m² ECOG performance status _____

ANC _____ Hemoglobin _____ Platelets _____ Creatinine _____ Lab date _____

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

Reason for switching _____

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.

Medication	Strength	Directions	Quantity	Refills
Breast cancer				
☐ Anastrozole Arimidex generic	1 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Letrozole Femara generic	2.5 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Exemestane Aromasin generic	25 mg tablet	Take 1 tablet by mouth once daily after a meal	30 tablets	_____
☐ Tamoxifen generic	10 mg or 20 mg tablet	Take 20 mg by mouth once daily	30-day supply	_____
☐ Kisqali ribociclib	200 mg tablet	Take 600 mg (3 tablets) daily, 21 days on, 7 days off	63 tablets	_____
☐ Capecitabine Xeloda generic	150 mg or 500 mg tablet	Take ____ mg twice daily, 14 days on, 7 days off	____ tablets	_____
Prostate cancer				
☐ Abiraterone Zytiga generic; give with prednisone	250 mg or 500 mg tablet	Take 1,000 mg once daily on an empty stomach	30-day supply	_____
☐ Bicalutamide Casodex generic	50 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
Blood cancers				
☐ Imatinib Gleevec or generic	100 mg or 400 mg tablet	Take ____ mg by mouth once daily with food	30-day supply	_____
☐ Dasatinib Sprycel or generic	20 to 140 mg tablet	Take ____ mg by mouth once daily	30 tablets	_____
☐ Nilotinib Tasigna or generic capsules	150 mg or 200 mg capsule	Take ____ mg twice daily on an empty stomach	30-day supply	_____
☐ Hydroxyurea Hydrea generic	500 mg capsule	Take ____ mg by mouth once daily	30-day supply	_____
☐ Mercaptopurine generic	50 mg tablet	Take ____ mg by mouth once daily	30-day supply	_____
☐ Rydapt midostaurin	25 mg capsule	Take ____ mg by mouth twice daily with food	____ capsules	_____
Other cancers				
☐ Temozolomide Temodar generic	5 to 250 mg capsules	Take ____ mg by mouth once daily for ____ days	____ capsules	_____
☐ Everolimus Afinitor generic	2.5, 5, 7.5 or 10 mg tablet	Take 10 mg by mouth once daily	30 tablets	_____
☐ Sunitinib Sutent generic	12.5 to 50 mg capsule	Take ____ mg daily, 4 weeks on, 2 weeks off	28 capsules	_____
☐ Pazopanib Votrient or generic	200 mg tablet	Take 800 mg once daily on an empty stomach	120 tablets	_____
☐ Gefitinib Iressa generic	250 mg tablet	Take 1 tablet by mouth once daily	30 tablets	_____
☐ Tabrecta capmatinib	150 mg or 200 mg tablet	Take 400 mg by mouth twice daily	30-day supply	_____
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.