

**Patient Information**

patient: \_\_\_\_\_ male  
last name, first name female DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

address: \_\_\_\_\_  
street city state zip

primary phone number: \_\_\_\_\_ cell alternate phone number: \_\_\_\_\_ cell

caregiver: \_\_\_\_\_ caregiver phone number: \_\_\_\_\_

allergies: \_\_\_\_\_ NKDA

**Clinical Information**

Primary Diagnosis/ICD-9: 204.12 205.10 205.12 205.11 other (please specify): \_\_\_\_\_

Complete this section ONLY if you would like Rx International Pharmacy to initiate a prior authorization or appeal on your behalf:

reason for discontinuation of therapy

prior therapy	resistance	intolerance (please specify)	other (please specify)	year of discontinuation
Gleevec <sup>®</sup>				
Sprycel <sup>®</sup>				
Tasigna <sup>®</sup>				
Other (please specify) _____				

patient weight: \_\_\_\_\_ lbs kg date: \_\_\_\_\_ patient height: \_\_\_\_\_ inches cm BSA<sup>1</sup>: \_\_\_\_\_ m<sup>2</sup>

<sup>1</sup>BSA calculator available at synribohcp.com

Prescription	Directions	Quantity	Refills
Synribo <sup>®</sup> 3.5 mg (1 mL) single-use vial (prescriber office administration)	induction dosing Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	_____ single-use vials	_____
	maintenance dosing Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	_____ single-use vials	_____
Synribo <sup>®</sup> _____ mg (1 mL) prefilled syringe <sup>2</sup> (patient home administration)	induction dosing Inject _____ mg Sub-Q BID for 14 days of a 28—day cycle	_____ single-use vials <sup>3</sup>	_____
	maintenance dosing Inject _____ mg Sub-Q BID for 7 days of a 28—day cycle	_____ single-use vials <sup>3</sup>	_____

<sup>2</sup> Pharmacy to coordinate shipment in accordance with drug stability (144 hours [6 days] after reconstitution)

<sup>3</sup> 1 vial = 1 prefilled syringe, unless the dose is > 3.5 mg (1 mL)

**Prescriber + Shipping Information**

prescriber (print): \_\_\_\_\_ office contact: \_\_\_\_\_

preferred method of contact: phone fax email preferred contact persons email: \_\_\_\_\_

ship to: patient office alternate: \_\_\_\_\_  
street city state zip

office address: \_\_\_\_\_  
(street, suite, city, state, zip)

phone: \_\_\_\_\_ fax: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

prescriber's signature: \_\_\_\_\_ date: \_\_\_\_\_

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

**Insurance Information: please fax copy of insurance card (front + back)**

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