

ONCOLOGY REFERRAL FORM (A-T)

PHONE 888.370.1724 | FAX 877.645.7514



Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION					
Last Name	First Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Last 4 SSN	Primary Language
Address			City	State	ZIP
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)			Alt Contact Email	Alt Contact Phone	

PRESCRIBER INFORMATION					
Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email			Office Phone	Office Fax	
Practice / Facility Name			Prescriber Name / Specialty		
Address		City	State	ZIP	
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #		

** Please include a copy of the front and back of insurance card **

CLINICAL INFORMATION - Please include applicable clinical chart notes					
Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:					Date Medication Needed
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)					
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> Code: Description:					

PRESCRIPTION INFORMATION - Please Escribe if required by state law
In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

ORAL ONCOLOGY AGENTS					
<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> Braftovi	<input type="checkbox"/> Fareston	<input type="checkbox"/> Inrebic	<input type="checkbox"/> Mektovi	<input type="checkbox"/> Piqray
<input type="checkbox"/> Afinitor	<input type="checkbox"/> Capecitabine	<input type="checkbox"/> Farydak	<input type="checkbox"/> Jakafi	<input type="checkbox"/> Mercaptopurine	<input type="checkbox"/> Rezerox
<input type="checkbox"/> Afinitor Disperz	<input type="checkbox"/> Daurismo	<input type="checkbox"/> Femara	<input type="checkbox"/> Kisqali	<input type="checkbox"/> Mesnex	<input type="checkbox"/> Rydapt
<input type="checkbox"/> Alkeran	<input type="checkbox"/> Emcyt	<input type="checkbox"/> Gavreto	<input type="checkbox"/> Kisqali + Femara Co-Pack	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Scemblix
<input type="checkbox"/> Anastrozole	<input type="checkbox"/> Erivedge	<input type="checkbox"/> Gleevec	<input type="checkbox"/> Lapatinib	<input type="checkbox"/> Mylotarg	<input type="checkbox"/> Soltamox
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Erleada	<input type="checkbox"/> Gleostine	<input type="checkbox"/> Lenvima	<input type="checkbox"/> Nilandron	<input type="checkbox"/> Sorafenib
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Erlotinib	<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Letrozole	<input type="checkbox"/> Nilutamide	<input type="checkbox"/> Sprycel
<input type="checkbox"/> Besponsa	<input type="checkbox"/> Etoposide	<input type="checkbox"/> Hydroxyurea	<input type="checkbox"/> Leucovorin	<input type="checkbox"/> Ninlaro	<input type="checkbox"/> Sunitinib Malate
<input type="checkbox"/> Bexarotene	<input type="checkbox"/> Everolimus	<input type="checkbox"/> Ibrance	<input type="checkbox"/> Leukeran	<input type="checkbox"/> Nolvadex	<input type="checkbox"/> Sutent
<input type="checkbox"/> Bicalutamide	<input type="checkbox"/> Everolimus Soluble	<input type="checkbox"/> Imatinib Mesylate	<input type="checkbox"/> Lorbrena	<input type="checkbox"/> Odomzo	<input type="checkbox"/> Tabrecta
<input type="checkbox"/> Bosulif	<input type="checkbox"/> Exemestane	<input type="checkbox"/> Inlyta	<input type="checkbox"/> Mekinist	<input type="checkbox"/> Onureg	<input type="checkbox"/> Tafinlar

Dose: _____ Tablets Capsules Other: _____ Qty: _____ Refills: _____

Directions: _____

BMS REMS PRODUCTS			
REVLIMID* <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	Risk Category <input type="checkbox"/> ADULT Female, NOT of Reproductive Potential <input type="checkbox"/> ADULT Female, Reproductive Potential <input type="checkbox"/> ADULT Male <input type="checkbox"/> Female CHILD, NOT of Reproductive Potential <input type="checkbox"/> Female CHILD, Reproductive Potential <input type="checkbox"/> Male CHILD Celgene Auth #: _____		
THALOMID* <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Take 1 capsule PO once daily. QTY: 28 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	Date Issued: _____ Confirmation #: _____ Date Issued: _____		
POMALYST* <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg <input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle. QTY: 21 0 Refills <input type="checkbox"/> Other: _____ QTY: ____ 0 Refills	Date Issued: _____		

_____ Prescriber Signature	_____ Date	_____ Supervising Physician Signature (where required by state law)	_____ Date
_____ DAW (Dispense as Written)	_____ Date	_____ Brand Necessary (must handwrite)	

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.

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PRESCRIBER INFORMATION					
Name of Contact Sending Referral		Title	Preferred Contact Method (check one) <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax		
Referral Contact Email		Office Phone		Office Fax	
Practice / Facility Name		Prescriber Name / Specialty			
Address		City		State	ZIP
Prescriber State License #	DEA #	NPI #		Medicaid UPIN #	

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CLINICAL INFORMATION - Please include applicable clinical chart notes					
Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy:				Date Medication Needed	
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)					
Sample/Starter Provided? <input type="checkbox"/> No <input type="checkbox"/> Yes, Provide Qty:	Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)					
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)					
Ship to Address <input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)					
ICD-10 Code <input type="checkbox"/> Code: Description:					

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ORAL ONCOLOGY AGENTS		
<input type="checkbox"/> Talzenna	<input type="checkbox"/> Xalkori	<input type="checkbox"/> Other:
<input type="checkbox"/> Tarceva	<input type="checkbox"/> Xeloda	<input type="checkbox"/> Other:
<input type="checkbox"/> Targretin	<input type="checkbox"/> Xtandi	<input type="checkbox"/> Other:
<input type="checkbox"/> Tassigna	<input type="checkbox"/> Xatmep	<input type="checkbox"/> Other:
<input type="checkbox"/> Temodar	<input type="checkbox"/> Yonsa	<input type="checkbox"/> Other:
<input type="checkbox"/> Temozolomide	<input type="checkbox"/> Zolanza	<input type="checkbox"/> Other:
<input type="checkbox"/> Toremifene Citrate	<input type="checkbox"/> Zykadia	<input type="checkbox"/> Other:
<input type="checkbox"/> Tretinoin	<input type="checkbox"/> Zytiga	<input type="checkbox"/> Other:
<input type="checkbox"/> Tykerb	<input type="checkbox"/> Other:	
<input type="checkbox"/> Vizimpro	<input type="checkbox"/> Other:	
<input type="checkbox"/> Votrient	<input type="checkbox"/> Other:	

Dose: _____	<input type="checkbox"/> Tablets <input type="checkbox"/> Capsules <input type="checkbox"/> Other: _____	Qty: _____	Refills: _____
Directions: _____			

BMS REMS PRODUCTS			
REVLIMID* <input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg			Risk Category
<input type="checkbox"/> Take 1 capsule PO once daily.	QTY: 28	0 Refills	<input type="checkbox"/> ADULT Female, NOT of Reproductive Potential
<input type="checkbox"/> Take 1 capsule PO daily; days 1-21 of 28-day cycle.	QTY: 21	0 Refills	<input type="checkbox"/> ADULT Female, Reproductive Potential
<input type="checkbox"/> Other: _____	QTY: _____	0 Refills	<input type="checkbox"/> ADULT Male
THALOMID* <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg			<input type="checkbox"/> Female CHILD, NOT of Reproductive Potential
<input type="checkbox"/> Take 1 capsule PO once daily.	QTY: 28	0 Refills	<input type="checkbox"/> Female CHILD, Reproductive Potential
<input type="checkbox"/> Other: _____	QTY: _____	0 Refills	<input type="checkbox"/> Male CHILD
POMALYST* <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg			Celgene Auth #: _____
<input type="checkbox"/> Take 1 capsule PO once daily, days 1-21 of 28-day cycle.	QTY: 21	0 Refills	Date Issued: _____
<input type="checkbox"/> Other: _____	QTY: _____	0 Refills	Confirmation #: _____
			Date Issued: _____

Prescriber Signature _____	Date _____	Supervising Physician Signature (where required by state law) _____	Date _____
DAW (Dispense as Written) _____	Date _____	Brand Necessary (must handwrite) _____	

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