ONCOLOGY REFERRAL FORM (A-T)

PHONE 888.370.1724 | **FAX** 877.645.7514

AMBER SPECIALTY PHARMACY

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 ☐ M ☐ F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ 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) ☐ Email ☐ Phone ☐ 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 ☐ Yes ☐ No, Start Date of Current Therapy:	Date Medication Needed			
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)				
Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided:	Patient Height (cm/in):	Weight (kg/lbs):	Date Obtained:	
Other/Concomitant Medications (please list)				
Allergies ☐ NKDA ☐ Drug Allergies (please list)				
Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)				
ICD-10 Code ☐ 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

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

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

Directions: _____

BMS REMS PRODUCTS

REVLIMID® ☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg

☐ Take 1 capsule PO once daily.	QTY: 28	0 Refills
☐ Take 1 capsule PO daily; days 1-21 of 28-day cycle.	QTY: 21	0 Refills
☐ Other: _____	QTY: ___	0 Refills

THALOMID® ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg

☐ Take 1 capsule PO once daily.	QTY: 28	0 Refills
☐ Other: _____	QTY: ___	0 Refills

POMALYST® ☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg

☐ Take 1 capsule PO once daily, days 1-21 of 28-day cycle.	QTY: 21	0 Refills
☐ Other: _____	QTY: ___	0 Refills

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

Celgene Auth #: _____

Date Issued: _____

Confirmation #: _____

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.*

REV.11.22

ONCOLOGY REFERRAL FORM (T-Z)

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ORAL ONCOLOGY AGENTS

☐ Tarceva	☐ Xeloda	☐ Other:
☐ Targretin	☐ Xtandi	☐ Other:
☐ Tasigna	☐ Xatmep	☐ Other:
☐ Temodar	☐ Yonsa	☐ Other:
☐ Temozolomide	☐ Zolinza	☐ Other:
☐ Toremifene Citrate	☐ Zykadia	☐ Other:
☐ Tretinoin	☐ Zytiga	☐ Other:
☐ Tykerb	☐ Other:	
☐ Vizimpro	☐ Other:	
☐ Votrient	☐ Other:	
☐ Xalkori	☐ Other:	

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

Directions: _____

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