ONCOLOGY REFERRAL FORM

Phone: 877-778-0318 Fax: 877-778-0399

Ship to: ☐ Patient ☐ Physician / Clinic Date Shipment Needed: _____ **Rx:** ☐ New ☐ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Patient's Social Security Number: _____

Patient's Date of Birth: _____

Allergies: _____

Patient's Gender (Male or Female): _____

Diagnosis: _____ **ICD10 Code:** _____

Patient Weight: _____ Height: _____

Primary Insurance: _____

ID #: _____ Phone: _____

Secondary Insurance: _____

ID #: _____ Phone: _____

OR PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

PRESCRIPTION INFORMATION

☐ Pomalyst ☐ Revlimid ☐ Thalomid

☐ Female Child - NOT of Reproductive Potential
☐ Female Child - Reproductive Potential
☐ Male Child

☐ Adult Female - NOT of Reproductive Potential
☐ Adult Female - Reproductive Potential
☐ Adult Male

Dose: _____ Qty: _____ Sig: _____

Authorization: _____ Date: _____ Confirmation #: _____ Date: _____ *(Pharmacy Use Only)*

☐ Dexamethasone Dose: _____ Qty: _____ Directions: _____

☐ Zytiga 250mg 4 QD (on empty stomach) Qty: _____ Refill: _____

☐ WITH Prednisone 5mg BID with food Qty: _____ Refill: _____

☐ **I.V.I.G.**

ORAL DRUGS

☐ Afinitor	☐ Kisqali	☐ Odomzo	☐ Tykerb
☐ Arimidex	☐ Hycamtin	☐ Pomalyst	☐ Venclexta
☐ Aromasin	☐ Ibrance	☐ Revlimid	☐ Votrient
☐ Bosulif	☐ Imbruvica	☐ Rydapt	☐ Xalkori
☐ Cabometyx	☐ Inlyta	☐ Sprycel	☐ Xeloda
☐ Cometriq	☐ Iressa	☐ Stivarga	☐ Xtandi
☐ Cotellic	☐ Jadenu	☐ Sutent	☐ Zelboraf
☐ Erivedge	☐ Jakafi	☐ Tamoxifen	☐ Zolinza
☐ Evista	☐ Lonsurf	☐ Tafinlar	☐ Zydelig
☐ Fareston	☐ Mekinist	☐ Tagrisso	☐ Zykadia
☐ Farydak	☐ Nexavar	☐ Tarceva	☐ Zytiga
☐ Faslodex	☐ Ninlaro	☐ Tasigna	
☐ Femara	☐ Nolvadex	☐ Temodar	
☐ Gleevec	☐ Noxafil	☐ Thalomid	

DOSE/QUANTITY/DIRECTION:

Refill #: _____

INJECTABLES

☐ Aranesp	☐ Neulasta
☐ Arixtra	☐ Neupogen
☐ Epogen	☐ Nplate
☐ Folotyn	☐ Perjeta
☐ Fragmin	☐ Procrit
☐ Leukine	☐ Retacrit
☐ Lovenox	☐ Sandostatin
☐ Lupron	☐ Sylatron

IV INFUSION

- ☐ 5FU (Flurouracil)
- ☐ Alimta
- ☐ Avastin
- ☐ Cyclophosphamide
- ☐ Darzalex
- ☐ Doxorubicin
- ☐ Empliciti
- ☐ Erbitux
- ☐ Gazyva
- ☐ Herceptin
- ☐ Kadcyla
- ☐ Keytruda
- ☐ Reclast
- ☐ Rituxan
- ☐ Taxotere

SUPPORT DRUGS

- ☐ Aspirin
- ☐ Allopurinol
- ☐ Coumadin
- ☐ Dexamethasone
- ☐ Emend
- ☐ Granix
- ☐ Jadenu
- ☐ Prednisone
- ☐ Promacta
- ☐ Rasburicase
- ☐ Sancuso
- ☐ Zarxio
- ☐ Zofran

ADJUNCT THERAPY

☐ Casodex	☐ Trelstar
☐ Eulexin	☐ Vantas
☐ Firmagon	☐ Zoladex
☐ Lupron Depot	
☐ Nilandron	

DOSE/QUANTITY/DIRECTION:

Refill #: _____

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI #: _____ License #: _____

Address, City, State, Zip: _____ DEA #: _____

Phone: _____ Fax: _____ Contact Name: _____

Prescriber's Signature: _____ Date: _____

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

Revised 2/12/2024