Priority Health Pharmacy
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ONCOLOGY REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ Other _____ Diagnosis _____
☐ **Yes** ☐ **No** Is Patient currently on therapy? Date of next blood work _____
☐ **Yes** ☐ **No** Biopsy? Results _____

PRESCRIPTION

☐ AFINITOR	☐ ELOXATIN	☐ HERCEPTIN	☐ SIVEXTRO	☐ VELCADE	☐ ZYTIGA
☐ AVASTIN	☐ ETOPOSIDE	☐ KADCYLA	☐ SPRYCEL	☐ XELODA	☐ _____
☐ AROMASIN	☐ GLEEVEC (IMATINIB)	☐ MOZOBIL	☐ SYLATRON	☐ YERVOY	☐ _____
☐ DOCETAXEL		☐ OPDIVO	☐ TASIGNA	☐ ZOLINZA	☐ _____
☐ ERBITUX	☐ GRANIX	☐ RITUXAN	☐ TEMODAR	☐ ZOMETA	☐ _____

Strength _____ SIG: _____ QTY: _____ Refill: _____

☐ JADENU **Tablets** ☐ 90 mg ☐ 180 mg ☐ 360 mg | **Granules** ☐ 90 mg ☐ 180 mg ☐ 360 mg
SIG: Take ☐ 90 mg ☐ 180 mg ☐ 360 mg by mouth once daily QTY: _____ Refill: _____

☐ XGEVA **120 mg/1.7 mL (70 mg/mL) single-use vial**
☐ 120 mg subcutaneously every 4 weeks in the upper arm, upper thigh, or abdomen QTY: _____ Refill: _____
☐ 120 mg subcutaneously every 4 weeks in the upper arm, upper thigh, or abdomen WITH
Additional 120 mg doses on days 8 & 15 of the first month of therapy QTY: _____ Refill: _____

ANTIEMETICS ☐ Chemo-induced N/V
☐ **Compazine** ☐ **Emend** ☐ **Zofran** ☐ **Sancuso Transdermal Patch** ☐ **Other** _____
Dosage: _____ QTY: _____ Refill: _____

☐ NEUPOGEN ☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other_____
☐ Daily x _____ days ☐ Every week ☐ BIW ☐ TIW QTY: _____ Refill: _____
☐ NEULASTA 6 mg/0.6 mL solution PFS SQ **OR** ☐ OTHER_____ QTY: _____ Refill: _____
☐ NEULASTA 0.6mg/0.6mL ONPRO kit SQ **OR** ☐ OTHER_____ QTY: _____ Refill: _____
☐ PROCRIT ☐ 10,000 units SQ weekly ☐ 20,000 units SQ weekly ☐ 40,000 units SQ weekly
☐ Other_____ QTY: _____ Refill: _____

☐ ARANESP	☐ ARIXTRA	☐ CAPHOSOL	☐ _____
☐ NEUMEGA 5mg vial	☐ ZOFRAN	☐ _____	☐ _____

Dosage_____ SIG: _____ QTY: _____ Refill: _____

☐ ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.