AcariaHealth™
Specialty Pharmacy

Date Shipment Needed: ____________ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

Phone: 866.892.1580 • Fax: 866.892.2363

ONCOLOGY INFUSION REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ Please attach demographic information		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑Breast Cancer ❑Renal Cell Carcinoma ❑Colon Cancer ❑Colorectal Cancer ❑Non-small Cell Lung Cancer ❑Glioblastoma ❑Chronic Lymphocytic Leukemia ❑Non-Hodgkin's Lymphoma ❑BCG Refractory Carcinoma in Situ (CIS) of the Urinary Bladder when immediate cystectomy would be associated with morbidity and mortality ❑Malignant Melanoma, Unresectable or Metastatic ❑Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma ❑Multiple Myeloma ❑Other______________________________

- Cancer stage: ❑Stage 0 ❑Stage I ❑Stage II ❑Stage III ❑Stage IV ❑Other:______________________________
- Patient's medical history includes: ❑Current pregnancy ❑Shingles (herpes zoster) ❑Obstructive pulmonary disorders ❑Other______________________
- Blood transfusion required? ❑Yes ❑No If yes, Coombs test result: ______________________________
- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): ______________________________
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): ______________________________
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: ______________________________
- How long should patient wait before starting the new medication? ______________________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

Oral Chemotherapy:

❑**Farydak** ❑**Gazyva** ❑**Revlimid** ❑**Other:** ______________________________

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ________________________ ❑Cycle: ____________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ________________________ ❑Cycle: ____________ QTY: ____ Refills:____

Infusion Chemotherapy:

❑**Abraxane** ❑**Adcetris** ❑**Alimta** ❑**Arzerra** ❑**Avastin** ❑**Carboplatin** ❑**Cisplatin** ❑**Docetaxel** ❑**Darzalex** ❑**Emplicti** ❑**Erbitux** ❑**Gemcitabine** ❑**Herceptin** ❑**Ixempra** ❑**Jevtana** ❑**Kadcyla** ❑**Keytruda** ❑**Kyprolis** ❑**Opdivo** ❑**Oxaliplatin** ❑**Paclitaxel** ❑**Perjeta** ❑**Portrazza** ❑**Rituxan** ❑**Torisel** ❑**Velcade** ❑**Yervoy** ❑**Zometa** ❑**Other:** ______________________________

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

Pre-Infusion Medication:

❑**Acetaminophen** ❑**Diphenhydramine** ❑**Dexamethasone** ❑**Methylprednisolone** ❑**Other:** ______________________________

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

Antimetics: ❑**Chemotherapy-induced N/V** ❑**Radiation-induced N/V**

❑**Aloxi** ❑**Akynzeo** ❑**Emend** ❑**Dolasteron** ❑**Granisetron** ❑**Ondansetron** ❑**Prochlorperazine** ❑**Other:** ______________________

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

Supportive Agents:

❑**Arenesp** ❑**Epogen** ❑**Granix** ❑**Neupogen** ❑**Neulasta** ❑**Procrit** ❑**Prothelial** ❑**Zarxio** ❑**Other:** ______________________

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

❑Drug: ____________ ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

Herpes Zoster Prophylaxis:

❑**Antiviral** ❑Strength: ____________ ❑Sig: ______________________________ QTY: ____ Refills:____

Prescriber's Signature: ______________________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.