

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

ONCOLOGY INFUSION REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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 ASSESSMENT					
Primary Diagnosis: <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Renal Cell Carcinoma <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Colorectal Cancer <input type="checkbox"/> Non-small Cell Lung Cancer <input type="checkbox"/> Glioblastoma <input type="checkbox"/> Chronic Lymphocytic Leukemia <input type="checkbox"/> Non-Hodgkin's Lymphoma <input type="checkbox"/> BCG Refractory Carcinoma in Situ (CIS) of the Urinary Bladder when immediate cystectomy would be associated with morbidity and mortality <input type="checkbox"/> Malignant Melanoma, Unresectable or Metastatic <input type="checkbox"/> Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Cancer stage: <input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient's medical history includes: <input type="checkbox"/> Current pregnancy <input type="checkbox"/> Shingles (herpes zoster) <input type="checkbox"/> Obstructive pulmonary disorders <input type="checkbox"/> Other: _____ <input type="checkbox"/> Blood transfusion required? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Coombs test result: _____ <input type="checkbox"/> Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ <input type="checkbox"/> Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ <input type="checkbox"/> Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ <input type="checkbox"/> How long should patient wait before starting the new medication? _____ <input type="checkbox"/> Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID:			
PRESCRIPTION INFORMATION					
Oral Chemotherapy:					
<input type="checkbox"/> Farydak <input type="checkbox"/> Gazyva <input type="checkbox"/> Revlimid <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:	<input type="checkbox"/> Cycle:	QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:	<input type="checkbox"/> Cycle:	QTY: _____	Refills: _____
Infusion Chemotherapy:					
<input type="checkbox"/> Abraxane <input type="checkbox"/> Adcetris <input type="checkbox"/> Alimta <input type="checkbox"/> Arzerra <input type="checkbox"/> Avastin <input type="checkbox"/> Carboplatin <input type="checkbox"/> Cisplatin <input type="checkbox"/> Docetaxel <input type="checkbox"/> Darzalex <input type="checkbox"/> Emlincti <input type="checkbox"/> Erbitux <input type="checkbox"/> Gemcitabine <input type="checkbox"/> Herceptin <input type="checkbox"/> Ixempra <input type="checkbox"/> Jevtana <input type="checkbox"/> Kadcyca <input type="checkbox"/> Keytruda <input type="checkbox"/> Kyprolis <input type="checkbox"/> Opdivo <input type="checkbox"/> Oxaliplatin <input type="checkbox"/> Paclitaxel <input type="checkbox"/> Perjeta <input type="checkbox"/> Portrazza <input type="checkbox"/> Rituxan <input type="checkbox"/> Torisel <input type="checkbox"/> Velcade <input type="checkbox"/> Yervoy <input type="checkbox"/> Zometa <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
Pre-Infusion Medication:					
<input type="checkbox"/> Acetaminophen <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
Antiemetics: <input type="checkbox"/> Chemotherapy-induced N/V <input type="checkbox"/> Radiation-induced N/V					
<input type="checkbox"/> Aloxi <input type="checkbox"/> Akynzeo <input type="checkbox"/> Emend <input type="checkbox"/> Dolasteron <input type="checkbox"/> Granisetron <input type="checkbox"/> Ondansetron <input type="checkbox"/> Prochlorperazine <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
Supportive Agents:					
<input type="checkbox"/> Arenesp <input type="checkbox"/> Epogen <input type="checkbox"/> Granix <input type="checkbox"/> Neupogen <input type="checkbox"/> Neulasta <input type="checkbox"/> Procrit <input type="checkbox"/> Prothelial <input type="checkbox"/> Zarxio <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
<input type="checkbox"/> Drug:	<input type="checkbox"/> Strength:	<input type="checkbox"/> Sig:		QTY: _____	Refills: _____
Herpes Zoster Prophylaxis:					
<input type="checkbox"/> Antiviral		<input type="checkbox"/> Strength:	<input type="checkbox"/> 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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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