

ONCOLOGY INFUSION REFERRAL FORM



GLEN ROCK
Medical Pharmacy
Part of The Elwyn Pharmacy Group

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Toll Free: 866-888-3200

Today's Date

- CURRENT PATIENT**
 NEW PATIENT

Patient Name _____ SS# _____ DOB _____
 Height _____ Weight _____ Address _____ Apt # _____
 Male Female City _____ State _____ Zip _____
 Daytime Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work OR Patient will pick up at Physician Office Pharmacy Date Needed _____
 Allergies _____ Comorbidities _____
 Current Medications (if necessary, please fax a complete list) _____

Insured's Name _____ Relation to Patient _____
 Eligible for Medicare Yes No If yes, Medicare# _____ Prescription Card Yes No If Yes, Carrier _____
 Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite# _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

Diagnosis Breast Cancer Renal Cell Carcinoma Colon Cancer Colorectal Cancer Non-small cell lung cancer
 Glioblastoma Chronic Lymphocytic Leukemia Non-Hodgkin's Lymphoma Other _____
 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
 Cancer Stage: Stage 0 Stage I Stage II Stage III Stage IV Other _____
 Has patient been treated previously for this condition? Yes No (If pt has been on Xeloda, please indicate dose and duration of therapy below)
 Medications: _____
 Is patient currently on therapy? Yes No Medications: _____
 Will patient stop taking the above medication(s) before starting the new medication?
 Yes No If yes, what is the washout period? _____
 Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ARZERRA Dosage: _____ QTY: _____ Infusion Cycle(s) Refills: _____

AVASTIN Dosage: _____
100 mg/4 ml; 400 mg/16 ml QTY: _____ Infusion Cycle(s) Refills: _____

GAZYVA Dosage: _____
QTY: _____ Infusion Cycle(s) Refills: _____

HERCEPTIN Dosage: _____
440 mg Multi-dose vial QTY: _____ Infusion Cycle(s) Refills: _____

IXEMPRA Dosage: 40 mg/m² _____ mg IV over 3 hrs every 3 wks
15 mg; 45 mg vial QTY: _____ Infusion Cycle(s) Refills: _____
Other: _____ QTY: _____ Infusion Cycle(s) Refills: _____

KADCYLA Dosage: _____
QTY: _____ Infusion Cycle(s) Refills: _____

PERJETA 420 mg/ 14 ml Vial Note: Dilute with NS--- Do NOT use D5W
Initial Dose: 840 mg IV over 60 min Qty: 2 vials Refills: 0
Maintenance Dose: 420 mg IV over 30-60 min every 3 weeks
Other: _____ QTY: _____ Infusion Cycle(s) Refills: _____

RITUXAN Dosage: _____
100 mg/10 ml; 500 mg/50 ml QTY: _____ Infusion Cycle(s) Refills: _____

YERVOY 50 mg/10 ml; 200 mg/40 ml
Dosage: 3 mg/kg _____ mg IV over 90 minutes Q 3 weeks for a
total of 4 doses Qty: Total of 4 infusion cycle (or one cycle with 3 refills)
Other: _____ QTY: _____ Infusion Cycle(s) Refills: _____
(Note: permanently discontinue if treatment cannot be completed
within 16 weeks from administration of first dose)

ALIMTA
 ABRAXANE
 ADCETRIS
 CARBOPLATIN
 CISPLATIN
 DOCETAXEL
 ERBITUX
 GEMCITABINE
 JEVTANA
 OXALIPLATIN
 PACLITAXEL
 TORISEL
 VELCADE
 ZOMETA

Dosage: _____
Qty: _____
Refills: _____

COLONY STIMULATING FACTORS:

NEUPOGEN
 300 mcg SQ
 480 mcg SQ
 Other _____
 Daily x _____ days BIW
 Every Week TIW

NEULASTA
 PROCRIT
 EPOGEN
 40,000 units SQ weekly
 Other: _____

ARANESP
 NEUMEGA 5 mg vial

Dosage: _____
Qty: _____ Refills: _____

ANTIEMETICS

Chemo-induced N/V Radiation-induced N/V

ARZERRA **GRANISETRON**
 ALOXI **ONDANSETRON**
 DOLASETRON **PROCHLORPERAZINE**
 EMEND

Dosage: _____ Qty: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. 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 in error and then destroy this document immediately.

Please fax completed referral form to **Glen Rock Medical Pharmacy** at 201-444-5792 Visit www.GLENROCKMEDICALPHARMACY.com for online fillable forms.



NEW REFERRAL CHECKLIST

PLEASE USE THIS CHECKLIST FOR ONCOLOGY PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment.

All lab reports (or EMR) must contain the following information within the last 30 days.

Please forward any updates to us you receive from the insurance company regarding approvals or denials

REQUIRED INFORMATION:

- Patient name
- Patient Demographics (Address, Phone Number, DOB, etc...)
- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.

If the only card included is a medical card, please include local pharmacy information.

- MD name/NPI/Office contact/Phone number
- Drug indicated with refills
- MD signature and date on referral form
- Diagnosis Code
- Previous therapies listed
- Concurrent medications for same diagnosis
- Quantity, frequency and cycle of medication

Fax the requested documentation to (201) 444-5792
Toll Free: 1-866-888-3200 Direct Phone: (201) 444-3200
GlenRockMedicalPharmacy.com



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