ORAL ONCOLOGY REFERRAL FORM

GLEN ROCK Medical Pharmacy
Part of The Elwyn Pharmacy Group

210 Rock Road | Glen Rock, NJ 07452
TEL: 610-545-6040 | FAX: 610-545-6030
1-866-317-0672

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 ☐ C92.10 Chronic Myeloid Leukemia ☐ C64.9 Renal Cell Carcinoma ☐ C71.9 Glioblastoma ☐ C50.919 Breast Cancer, unspecified
☐ C84.00 Cutaneous T-Cell Lymphoma (Mycosis Fungoides), unspecified ☐ C84.17 Cutaneous T-Cell Lymphoma (Sezary's Disease), unspecified
☐ C17.9 Gastrointestinal Stromal Tumors ☐ C34.90 Pulmonary Malignancy, unspecified ☐ C25.9 Adenocarcinoma of Pancreas, unspecified
☐ C90.00 Multiple Myeloma ☐ L52 Erythema Nodosum (ENL) ☐ C22.0 Hepatocellular Carcinoma ☐ Other _____
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

☐ **AFINITOR** ☐ 2.5 mg tab ☐ 5 mg tab ☐ 7.5 mg tab ☐ 10 mg tab
☐ **BOSULIF** ☐ 100 mg tab ☐ 500 mg tab
☐ **CAPECITABINE**
1250 mg/m² po BID for 14 days followed by 7 days of rest (2 weeks on, 1 week off)
Please indicate number of tablets to be taken at each dose:
Dosage: (____ of 500 mg & ____ of 150 mg tabs) QAM & (____ of 500 mg & ____ of 150 mg tabs) QPM for ____ days followed by ____ days of rest.
☐ **GLEEVEC** ☐ 100 mg tab ☐ 400 mg tab
(will dispense combination of 100 mg and 400 mg tab based on patient's dose)
☐ **HYCAMTINE** ☐ 0.25 mg tab ☐ 1 mg tab
☐ **INLYTA** ☐ 1 mg tab ☐ 5 mg tab
(will dispense combination of 1 mg and 5 mg tab based on patient's dose)
☐ **MEKINIST** ☐ 0.5 mg tab ☐ 1 mg tab ☐ 2 mg tab
☐ **NEXAVAR** ☐ 200 mg tab
☐ **PROMACTA** ☐ 12.5 mg tab ☐ 25 mg tab ☐ 50 mg tab ☐ 75 mg tab ☐ 100 mg tab
☐ **SPRYCEL** ☐ 20 mg tab ☐ 50 mg tab ☐ 70 mg tab ☐ 80 mg tab ☐ 100 mg tab ☐ 140 mg tab

☐ **STIVARGA** ☐ 40 mg tab
☐ **SUTENT** ☐ 12.5 mg cap ☐ 25 mg cap ☐ 50 mg cap ☐ 50 mg po daily for 4 wks on and 2 wks off
☐ **TAFINLAR** ☐ 50 mg cap ☐ 75 mg cap
☐ **TARCEVA** ☐ 25 mg tab ☐ 100 mg tab ☐ 150 mg tab
☐ **TASIGNA** ☐ 150 mg cap ☐ 200 mg cap
☐ **TEMOZOLOMIDE** ☐ 5 mg cap ☐ 20 mg cap ☐ 100 mg cap ☐ 140 mg cap ☐ 180 mg cap ☐ 250 mg cap
Total daily dose based on BSA: _____mg POI daily for _____ days off,
repeat cycle every _____ days for _____ cycles.
☐ **THALOMID** ☐ 50 mg cap ☐ 100 mg cap ☐ 150 mg cap ☐ 200 mg cap
☐ **TYKERB** ☐ 250 mg tab
☐ **VOTRIENT** ☐ 200 mg tab
☐ **XTANDI** ☐ 40 mg cap ☐ 160 mg (four 40 mg caps) PO daily ☐ ALT. DOSAGE: _____
☐ **ZYTIGA** ☐ 250 mg tab; 4 times daily (1000 mg)
☐ In combination w/Prednisone 5mg tab BID ☐ ALT. DOSAGE: _____

☐ **OTHER**: _____
DOSAGE: _____ QTY: _____ Refills: _____
DOSAGE: _____ QTY: _____ Refills: _____

ANTIEMETICS

☐ Chemo-induced N/V ☐ Radiation-induced N/V
☐ **GRANISETRON** ☐ **EMEND** ☐ **ALOXI**
☐ **ONDANSETRON** ☐ **DOLASETRON** ☐ **PROCHLORPERAZINE**
Dosage: _____ Qty: _____ Refills: _____

SUPPORTIVE AGENTS

☐ **NEUPOGEN** ☐ **ARANESP** ☐ **NEULASTA**
☐ **PROCRIT** ☐ **EPOGEN**
Dosage: _____ Qty: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's 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**_____

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **610-545-6030** 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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