

# ORAL ONCOLOGY REFERRAL FORM



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

<input type="checkbox"/> <b>AFINITOR</b> <input type="checkbox"/> 2.5 mg tab <input type="checkbox"/> 5 mg tab <input type="checkbox"/> <input type="checkbox"/> 7.5 mg tab <input type="checkbox"/> 10 mg tab <input type="checkbox"/> <b>BOSULIF</b> <input type="checkbox"/> 100 mg tab <input type="checkbox"/> 500 mg tab <input type="checkbox"/> <b>CAPECITABINE</b> 1250 mg/m <sup>2</sup> 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. <input type="checkbox"/> <b>GLEEVEC</b> <input type="checkbox"/> 100 mg tab <input type="checkbox"/> 400 mg tab (will dispense combination of 100 mg and 400 mg tab based on patient's dose) <input type="checkbox"/> <b>HYCAMTINE</b> <input type="checkbox"/> 0.25 mg tab <input type="checkbox"/> 1 mg tab <input type="checkbox"/> <b>INLYTA</b> <input type="checkbox"/> 1 mg tab <input type="checkbox"/> 5 mg tab (will dispense combination of 1 mg and 5 mg tab based on patient's dose) <input type="checkbox"/> <b>MEKINIST</b> <input type="checkbox"/> 0.5 mg tab <input type="checkbox"/> 1 mg tab <input type="checkbox"/> 2 mg tab <input type="checkbox"/> <b>NEXAVAR</b> <input type="checkbox"/> 200 mg tab <input type="checkbox"/> <b>PROMACTA</b> <input type="checkbox"/> 12.5 mg tab <input type="checkbox"/> 25 mg tab <input type="checkbox"/> <input type="checkbox"/> 50 mg tab <input type="checkbox"/> 75 mg tab <input type="checkbox"/> 100 mg tab <input type="checkbox"/> <b>SPRYCEL</b> <input type="checkbox"/> 20 mg tab <input type="checkbox"/> 50 mg tab <input type="checkbox"/> 70 mg tab <input type="checkbox"/> <input type="checkbox"/> 80 mg tab <input type="checkbox"/> 100 mg tab <input type="checkbox"/> 140 mg tab <input type="checkbox"/> <b>OTHER:</b> DOSAGE: _____ QTY: _____ Refills: _____ DOSAGE: _____ QTY: _____ Refills: _____	<input type="checkbox"/> <b>STIVARGA</b> <input type="checkbox"/> 40 mg tab <input type="checkbox"/> <b>SUTENT</b> <input type="checkbox"/> 12.5 mg cap <input type="checkbox"/> 25 mg cap <input type="checkbox"/> <input type="checkbox"/> 50 mg cap <input type="checkbox"/> 50 mg po daily for 4 wks on and 2 wks off <input type="checkbox"/> <b>TAFINLAR</b> <input type="checkbox"/> 50 mg cap <input type="checkbox"/> 75 mg cap <input type="checkbox"/> <b>TARCEVA</b> <input type="checkbox"/> 25 mg tab <input type="checkbox"/> 100 mg tab <input type="checkbox"/> 150 mg tab <input type="checkbox"/> <b>TASIGNA</b> <input type="checkbox"/> 150 mg cap <input type="checkbox"/> 200 mg cap <input type="checkbox"/> <b>TEMOZOLOMIDE</b> <input type="checkbox"/> 5 mg cap <input type="checkbox"/> 20 mg cap <input type="checkbox"/> 100 mg cap <input type="checkbox"/> <input type="checkbox"/> 140 mg cap <input type="checkbox"/> 180 mg cap <input type="checkbox"/> 250 mg cap Total daily dose based on BSA: _____ mg POI daily for _____ days off, repeat cycle every _____ days for _____ cycles. <input type="checkbox"/> <b>THALOMID</b> <input type="checkbox"/> 50 mg cap <input type="checkbox"/> 100 mg cap <input type="checkbox"/> <input type="checkbox"/> 150 mg cap <input type="checkbox"/> 200 mg cap <input type="checkbox"/> <b>TYKERB</b> <input type="checkbox"/> 250 mg tab <input type="checkbox"/> <b>VOTRIENT</b> <input type="checkbox"/> 200 mg tab <input type="checkbox"/> <b>XTANDI</b> <input type="checkbox"/> 40 mg cap <input type="checkbox"/> 160 mg (four 40 mg caps) PO daily <input type="checkbox"/> <input type="checkbox"/> ALT. DOSAGE: _____ <input type="checkbox"/> <b>ZYTIGA</b> <input type="checkbox"/> 250 mg tab; 4 times daily (1000 mg) <input type="checkbox"/> <input type="checkbox"/> In combination w/Prednisone 5mg tab BID <input type="checkbox"/> ALT. DOSAGE: _____
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### 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 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 **610-545-6030** Visit [www.GLENROCKMEDICALPHARMACY.com](http://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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