



ORAL ONCOLOGY REFERRAL FORM

210 Rock Road | Glen Rock, NJ 07452
TEL: 201-444-3200 | FAX: 201-444-5792
Toll Free: 866-888-3200

Today's Date

CURRENT PATIENT
 NEW PATIENT

July 2017

Patient Name _____ SS# _____ DOB _____
Height _____ Weight _____ BSA _____ 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 Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____
<input type="checkbox"/>	# _____	<input type="checkbox"/>	# _____

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# _____

Diagnosis ICD-10: _____ Cancer Stage: Stage 0 Stage I Stage II Stage III Stage IV Other _____
Has patient been treated previously for this condition? Yes No (If patient 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? _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AFINITOR tablets 2.5 mg 5 mg 7.5 mg 10 mg
Sig: _____ Qty: _____ Refills: _____

BOSULIF tablets 100 mg 500 mg
Sig: _____ Qty: _____ Refills: _____

CAPECITABINE 150 mg 500 mg
Sig: _____ Qty: _____ Refills: _____

GLEEVEC tablets 100 mg 400 mg
Sig: _____ Qty: _____ Refills: _____

HYCAMTIN tablets 0.25 mg 1 mg
Sig: _____ Qty: _____ Refills: _____

IBRANCE capsules 75 mg 100 mg 125 mg
Sig: _____ Qty: _____ Refills: _____

IMBRUVICA capsules 140 mg
Sig: _____ Qty: _____ Refills: _____

INLYTA tablets 1 mg 5 mg
Sig: _____ Qty: _____ Refills: _____

MEKINIST tablets 0.5 mg 2 mg
Sig: _____ Qty: _____ Refills: _____

PROMACTA tablets 12.5 mg 25 mg 50 mg
 75 mg 100 mg
Sig: _____ Qty: _____ Refills: _____

SPRYCEL tablets 20 mg 50 mg 70 mg 80 mg
 100 mg 140 mg
Sig: _____ Qty: _____ Refills: _____

KISQALI 200mg tablets
Sig: Take 600 mg 400 mg 200 mg by mouth daily
for 21 days followed by a 7 day rest period
(must be administered in combination with other aromatase inhibitor)
Qty: 21 (200mg QD) 42 (400mg QD) 63 (600mg QD) Refills: _____

SUTENT 12.5 mg CAP 25 mg CAP 50 mg CAP
Sig: _____ Qty: _____ Refills: _____

TAFINLAR capsules 50 mg 75 mg
Sig: _____ Qty: _____ Refills: _____

TARCEVA tablets 25 mg 100 mg 150 mg
Sig: _____ Qty: _____ Refills: _____

TASIGNA capsules 150 mg 200 mg
Sig: _____ Qty: _____ Refills: _____

TEMOZOLOMIDE capsules 5 mg 20 mg 100 mg
 140 mg 180 mg 250 mg
Sig: _____ Qty: _____ Refills: _____

THALOMID capsules 50 mg 100 mg
 150 mg 200 mg
Sig: _____ Qty: _____ Refills: _____

TYKERB tablets 250 mg
Sig: _____ Qty: _____ Refills: _____

VOTRIENT tablets 200 mg
Sig: _____ Qty: _____ Refills: _____

XTANDI capsules 40 mg
Sig: _____ Qty: _____ Refills: _____

ZYTIGA tablets 250 mg; 4 tablets daily (1000 mg)
 Local Pharmacy providing Prednisone
 Please provide Prednisone 5mg BID
Sig: _____ Qty: 60 Refills: _____

SUPPORTIVE AGENTS **NEUPOGEN** **ARANESP** **NEULASTA**
 PROCRIT **EPOGEN** **XGEVA**
Dosage: _____ Qty: _____ Refills: _____

OTHER _____
Dosage: _____ Qty: _____ Refills: _____
Sig: _____

● = Restricted access medication as of June 2017

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** _____

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.

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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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