

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

ORAL ONCOLOGY 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: C17.9 Gastrointestinal Stromal Tumors C18.3 - C19 Metastatic Colorectal Cancer C22.0 - C22.2 - C22.7 - C22.8 Hepatocellular Carcinoma
 C25.9 Adenocarcinoma of Pancreas C34.90 Pulmonary Malignancy C50.019 Breast Cancer C64.9 Renal Cell Carcinoma 191.9 Glioblastoma
 C73 Malignant Neoplasm of Thyroid Gland C82.90 - C82.99 Cutaneous T-Cell Lymphoma (Mycosis Fungoides or Sezary's Disease)
 C90.00 - C90.01 - C90.02 Multiple Myeloma C92.10 - C92.11 - C92.12 Chronic Myeloid Leukemia L52 Erythema Nodosum (ENL) Other: _____

- Has patient been treated *previously* for this condition? Yes No Medication(s): _____
- Cancer Stage: Stage 0 Stage I Stage II Stage III Stage IV Other _____
- Is patient *currently* on therapy? Yes No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? Yes No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

INSURANCE INFORMATION

Please attach front and back of patient's insurance card (medical and prescription)

COPAY CARD ENROLLMENT

Please check if enrolling in copay card | Copay ID: _____

PRESCRIPTION INFORMATION

Medication	mg	QTY.	SIG.	Refills	Medication	mg	QTY.	SIG.	Refills
<input type="checkbox"/> Afinitor					<input type="checkbox"/> Sprycel				
<input type="checkbox"/> Bosulif					<input type="checkbox"/> Stivarga				
<input type="checkbox"/> Capecitabine					<input type="checkbox"/> Sutent				
<input type="checkbox"/> Erivedge					<input type="checkbox"/> Tafinlar				
<input type="checkbox"/> Erleada					<input type="checkbox"/> Tarceva				
<input type="checkbox"/> Gleevec					<input type="checkbox"/> Tassigna				
<input type="checkbox"/> Hycamtin					<input type="checkbox"/> Temodar				
<input type="checkbox"/> Inlyta					<input type="checkbox"/> Temozolomide				
<input type="checkbox"/> KISQALI					<input type="checkbox"/> Topotecan				
<input type="checkbox"/> Mekinist					<input type="checkbox"/> Tykerb				
<input type="checkbox"/> Nerlynx					<input type="checkbox"/> Votrient				
<input type="checkbox"/> Nexavar					<input type="checkbox"/> Xalkori				
<input type="checkbox"/> Nubeqa					<input type="checkbox"/> Xtandi				
<input type="checkbox"/> Odomzo					<input type="checkbox"/> Zytiga				
<input type="checkbox"/> Rydapt									

Other: _____ Dosage: _____ QTY: _____ Refills: _____

Antimetotics: Chemo-induced N/V Radiation-induced N/V
 Aloxi Akynzeo Dolasetron Emend Granisetron Prochlorperazine Ondansetron Other: _____
 Dosage: _____ QTY: _____ Refills: _____

Supportive Agents:
 Neupogen Neulasta Procrit Epogen Aranesp Prothelial Loperamide Other: _____
 Dosage: _____ 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 AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. 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 by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

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