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: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **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 ASSESEMENT

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
❑**Afinitor**					❑**Sprycel**				
❑**Bosulif**					❑**Stivarga**				
❑**Capecitabine**					❑**Sutent**				
❑**Erivedge**					❑**Tafinlar**				
❑**Erleada**					❑**Tarceva**				
❑**Gleevec**					❑**Tasigna**				
❑**Hycamtin**					❑**Temodar**				
❑**Inlyta**					❑**Temozolomide**				
❑**Kisqali**					❑**Topotecan**				
❑**Mekinist**					❑**Tykerb**				
❑**Nerlynx**					❑**Votrient**				
❑**Nexavar**					❑**Xalkori**				
❑**Nubeqa**					❑**Xtandi**				
❑**Odomzo**					❑**Zytiga**				
❑**Rydapt**									

❑**Other:** _____ ❑Dosage: _____ QTY: ____ Refills:____

Antimetics: ❑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.

9.10.19

Phone: 800.511.5144 ● Fax: 877.541.1503