Procare PHARMACY

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Oncology Prescription Referral Form (Form 1)

Date Medication needed : _____ Ship to : _____ PATIENT'S HOME _____ PRESCRIBER'S OFFICE INJECTION TRAINING BY PHARMACY ? ___

1: Patient Information

Patient Name: Birthdate: Sex: Male Female Height: Weight: lbs. kg.
Soc. Sec. #: Preferred Phone: Known Allergies: _____
Address: City: State: ZIP: _____
Alternate Caregiver Name: Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name(s):

NPI#: _____

Practice Info:

Practice Name: _____
Address: _____
City, State: ZIP:
Tax ID#: _____
Phone: Fax: _____
Key Contact: _____
Key Contact Phone: Key Contact Email: _____

3: Diagnosis/Clinical Information

*To expedite prior authorization services, **please FAX** current and past Chemo regimen(s)/schedule, last clinical notes and/or lab values/scans*

Diagnosis: _____
ICD-10: *(required for Medicare B billing)* BSA m^2
Renal Dysfunction: Yes No
Current SCr or current GFR ml/min
Liver Dysfunction: Yes No
Abnormal Lab Value(s) _____
H/H (Hemoglobin/Hematocrit): _____ _____
Confirmed Mutations: EGFR ALK BRAF V600E BRAF V600K
CLL with 17p deletion Other: _____

4: Prescription Information

SOLID TUMORS:

Afinitor	Mekinist	Xeloda
Afinitor Disperz	Nolvadex	Zykadia
Arimidex	Tafinlar	Zolinda
Erivedge	Temodar	
Femara	Tykerb	
Hycamtin	Votrient	

LIQUID TUMORS:

Exjade
Farydak
Gleevec
Sprycel
Tasigna

STRENGTH / DIRECTIONS (SIG) :
QUANTITY : _____ REFILLS : _____

KISQALI 600mg orally once daily for 21 days, then 7 days off Qty: _____ Refills: _____
w/ LETROZOLE 2.5mg orally one daily throughout the 28 days cycle Qty: _____ Refills: _____

POMALYST **THALOMID** **DEXAMETHASONE**

Please circle one:
Adult Female - NOT of reproductive potential
Female Child - NOT of reproductive potential
Adult Female - of reproductive potential
Female Child - of reproductive potential
Male Child
Adult Male

STRENGTH / DIRECTION (SIG)

PROVIDER AUTHORIZATION # _____ QUANTITY _____ REFILLS

Prescriber Signature: Prescriber, please sign and date below

DISPENSE AS WRITTEN Date Substitution Permissible Date

NINLARO One mg capsule once weekly on day 1,8 and 15 of a 28-day cycle, 1 hour before or 2 hours after food
Qty : 3 Capsules Refills : _____

DEXAMETHASONE
40mg (10 tablets) once weekly on day 1,8,15 and 22 of a 28-day cycle
QTY : _____ REFILLS : _____

ALLOPURINOL (STRENGTH)
SIG : _____
QTY : _____ REFILLS : _____

SUPPORTIVE MEDICATIONS (STRENGTH)

Aranesp	Nplate
Arixtra	Procrit
Emend	Promacta
Granix	Sancuso
Lovenox	Xgeva
Neulasta	Zarxio
Neupogen	Zofran

SIG : _____
QTY : _____ REFILLS : ____

I authorize Procare Pharmacy and its representatives to act as an agent to initiate and excecute the insurance prior authorization process

# of Prescriptions: _____

PRIOR AUTHORIZATION APPLICATION TO INSURANCE AND PATIENT SUPPORT PROGRAM ARE AVAILABLE AT PROCARE PHARMACY