

Add Logo

E-prescribe the *Fast & Easy* way: select **(Add company name)** from your EHR!**ORAL ONCOLOGY REFERRAL FORM**

Fax: (000) 000-0000

Phone: (000) 000-0000

**PATIENT INFORMATION**

Patient Name:		SSN:		DOB:	
Address:		City:		State:	Zip:
Home Phone:	Cell:	Height:	Weight:	Gender:	Male Female
Email:		Allergies:			
Primary Diagnosis:		Secondary Diagnosis			

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
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**PRESCRIPTION INFORMATION (or attach a copy of prescription)**

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID® (lenalidomide) <i>Complete lab section below</i>	<input type="checkbox"/> 2.5 mg <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 25 mg	<input type="checkbox"/> Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle. <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-14, of a 21 day cycle. <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-14, of a 28 day cycle <input type="checkbox"/> Take _____ caps by mouth once a day continuously on days 1-28.		None
THALOMID® (thalidomide)	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg	<input type="checkbox"/> Take _____ caps by mouth once daily at bedtime.		None
POMALYST® (pomalidomide)	<input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg	<input type="checkbox"/> Take _____ caps by mouth once daily on days 1-21, of a 28 day cycle.		None

Patient Type:     Adult Female, Not of Reproductive Potential     Adult Female, Reproductive Potential     Female Child, Not of Reproductive Potential  
 Female Child, Reproductive Potential     Adult Male     Male Child

Celgene Auth#:

Date Issued:

† To prevent delays and minimize phone calls please provide the following labs: Serum Creatinine: \_\_\_\_\_ eGFR/CrCL: \_\_\_\_\_ Date: \_\_\_\_\_

XELODA® (capecitabine)*† <i>Complete lab section above</i>	<input type="checkbox"/> 150 mg <input type="checkbox"/> 500 mg Total dose: _____ mg	<input type="checkbox"/> Take total dose by mouth twice daily on days 1-14 of 21 day cycle. Repeat. <input type="checkbox"/> Take total dose twice daily in conjunction with radiation: <input type="checkbox"/> M-F <input type="checkbox"/> 7 days/week    Radiation length of therapy: _____ <input type="checkbox"/> Other _____		
TEMODAR® (temozolomide)*	<input type="checkbox"/> Total dose: _____ mg tablet	<input type="checkbox"/> Take _____ mg by mouth once daily for 5 days every 28 days <input type="checkbox"/> Take _____ mg by mouth once daily in conjunction with radiation for _____ days Start Date _____ for _____ # of days a week. <input type="checkbox"/> Other _____		
Deferiprone	500 mg tablet	<input type="checkbox"/> Take _____ mg by mouth three times daily with or without food Recommended dosing 25 mg/kg to 33mg/kg body weight three time a day. Total daily dose of 75mg/kg to 99mg/kg		
JADENU™ (deferasirox)* † <input type="checkbox"/> Tablets <input type="checkbox"/> Sprinkle Granules	<input type="checkbox"/> 90 mg <input type="checkbox"/> 180 mg <input type="checkbox"/> 360 mg	<input type="checkbox"/> Take _____ mg by mouth once daily with or without a light meal.		
EXJADE® (deferasirox)* † Tablets for Suspension	<input type="checkbox"/> 125 mg <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg by mouth once daily on an empty stomach at least 30 minutes before food.		
ZYTIGA® (abiraterone acetate)*	<input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg	<input type="checkbox"/> Take _____ mg by mouth once daily.		
with PREDNISONE	_____ mg	<input type="checkbox"/> CRPC: Take 5 mg by mouth twice daily with food <input type="checkbox"/> CSPC: Take 5 mg by mouth once daily with food		
<b>Sorafenib</b>	200 mg tablets	400 mg (2 tablets) orally twice daily without food		

AFINITOR® (everolimus)*	CYTOXAN® (cyclophosphamide)*	GAVRETO® (pralsetinib)	LORBRENA® (lorlatinib)†	ONUREG® (azacitidine)	TALZENNA® (talazoparib)	XALKOR® (crizotinib)†
AGRYLIN® (anagrelide)*	DAURISMO™ (glasdegib)	GLEEVEC® (imatinib)*†	LENVIMA® (lenvatinib)	PIQRAY® (alpelisib)	TARCEVA® (erlotinib)*	XTANDI® (enzalutamide)
ALECENSA® (alectinib)	ERIVEDGE™ (vismodegib)	IBRANCE® (palbociclib)	MEKINIST™ (trametinib)	ROZLYTREK® (ertrectinib)	TARGRETIN® (bexarotene)*	YONSA® (abiraterone acetate)
BESPONSA® (nintedanib mesylate)	ERLEADA™ (apalutamide)	INLYTA® (axitinib)	MEKTOV® (binimetinib)	RYDAPT® (micostaurin)	TASIGNA® (nilotinib)	ZELBORAF® (vemurafenib)
BOSULIF® (bosutinib) †	FARYDAK® (panobinostat)	KISQALI® (ribociclib) †	MYLOTARG™ (gemtuzumab ozogamicin)	SPRYCEL® (dasatinib)	TYKERB® (lapatinib)*	ZOLINZA™ (vorinostat)
BRAFTOVI® (encorafenib)	FASLODEX (flvestrant)*	FEMARA® (letrozole)*	NILANDRON® (nilutamide)	SUTENT® (sunitinib malate)	VIZIMPRO® (dacomitinib)	
COTELLIC® (cobimetinib)	FORTEO® (teriparatide)		ODOMZO® (sonidegib)	TAFINLAR® (dabrafenib)	VOTRIENT® (pazopanib)	

\*AVAILABLE IN GENERIC

Drug Name (write in one of the above): \_\_\_\_\_  
 Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
Drug Name (write in one of the above): \_\_\_\_\_  
 Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_  
Drug Name (write in one of the above): \_\_\_\_\_  
 Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

**Start of Therapy Date:**Ship To:     Patient     MD OfficeAs required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.     Dispense as written**PHYSICIAN INFORMATION**

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date:	

Your signature authorizes (add company name) Pharmacy Services, LLC, and their network of pharmacies, to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients. ©2023 CarepathRx. All rights reserved.