AcariaHealth
Specialty Pharmacy

Phone: 866.892.1580 • Fax: 866.892.2363

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

HEPATOCELLULAR CARCINOMA (HCC)
RENAL CELL CARCINOMA (RCC) 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 ASSESMENT

Primary Diagnosis: ❑C22.0 Hepatocellular Carcinoma (HCC) ❑C22.2; C22.7; C22.8; C64.9 Renal Cell Carcinoma (RCC) ❑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):
  _____
- *Afinitor* Rx Only: Did patient fail *Sutent*? ❑Yes ❑No

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
❑**Afinitor**				
❑**Avastin**				
❑**Inlyta**				
❑**Nexavar**				
❑**Promatca**				
❑**Sutent**				
❑**Torisel**				
❑**Votrient**				
❑**Other**				

❑**Antimetics** ❑Chemo-induced N/V ❑Radiation-induced N/V
❑Aloxis ❑Emend ❑Dolasetron ❑Granisetron ❑Ondansetron ❑Prochlorperazine QTY: _____ Refills: _____
❑Other: _____ QTY: _____ Refills: _____
❑Dosage: _____

❑**Supportive Agents**
❑Aranesp ❑Epogen ❑Neulasta ❑Neupogen ❑Procrit ❑Prothelial QTY: _____ Refills: _____
❑Other: _____ QTY: _____ Refills: _____
❑Dosage: _____

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.

3.15.19