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.

MELANOMA 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

- Has patient been treated previously for this condition? ❑Yes ❑No Medications:_____
- Is patient currently on therapy? ❑Yes ❑No Medications:_____
- ❑Yes ❑No If yes, what is the washout period?_____
- 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	SIG	QTY	Refills
❑Intro-A Vial				
❑Keytruda				
❑Mekinist				
❑Opdivo				
❑Paclitaxel				
❑Sylatron				
❑Tafinlar				
❑Temozolomide				
❑Yervoy				
Antiemetics				
❑Aloxi				
❑Emend				
❑Dolasetron				
❑Granisetron				
❑Ondansetron				
❑Prochlorperazine				
Supportive Agent				
❑Acetaminophen				
❑Aranesp				
❑Diphenhydramine				
❑Epogen				
❑Famotidine				
❑Lorazepam				
❑Neulasta				
❑Neupogen				
❑Procrit				
❑Prothelial				
❑Ranitidne				

I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to AcariaHealth 6923 Lee Vista Blvd, Suite 300 Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original

Patient Signature *(required for participation)* _____ Date _____

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 electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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