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

ONCOLOGY UROLOGY 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: ❑C18.9 Malignant Neoplasm of Colon ❑C61 Prostate Cancer ❑C61 Renal Cell Carcinoma (RCC) ❑D09.0 Carcinoma in situ of bladder ❑Prevention of SREs in patients with Bone Metastasis from Solid tumors ❑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**					❑Lupron Depot	7.5 mg	1 injection		
❑**Avastin**					❑Lupron Depot	22.5 mg	1 injection		
❑**Inlyta**					❑Lupron Depot	30 mg	1 injection		
❑**Nexavar**					❑Lupron Depot	45 mg	1 injection		
❑**Sutent**					❑Leuprolide	5 mg/ml			
❑**Stivarga**					❑Eligard	7.5 mg	1 injection		
❑**Torisel**					❑Eligard	22.5 mg	1 injection		
❑**Valstar**					❑Eligard	30 mg	1 injection		
❑**Votrient**					❑Eligard	45 mg	1 injection		
❑**Xgeva**					❑Trelstar	3.75 mg	1 injection		
❑**Xtandi**					❑Trelstar	11.25 mg	1 injection		
❑**Zytiga**					❑Trelstar	22.5 mg	1 injection		
❑**Zoladex**					❑Vantas	50 mg	1	Contraindicated in pediatric patietns, implant inserted SQ for 12 months	

❑**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 ❑Neumega ❑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 the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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