ORAL ONCOLOGY REFERRAL FORM

Jersey Shore Pharmacy

580 N. Main Street • Barnegat, NJ 08005
Phone: 609-660-1111 • Fax: 609-660-0101

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ Date of Birth _____
☐ Male ☐ Female SS# _____ Language _____
Address _____ Apt # _____
City _____ State _____ ZIP _____
Phone _____ Cell _____ Email _____
Allergies _____
Ship to Patient at ☐ Home ☐ Work
OR Patient will pick up at ☐ Jersey Shore Pharmacy ☐ Physician Office

Insured's Name _____
Relation to Patient _____
Eligible for Medicare? ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Phone _____ Fax _____
Policy/Group# _____
Bin# _____ Pcn# _____
RXID# _____ RX Group# _____

ICD-10 Code _____ Diagnosis _____ Cancer Stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Other _____
Has patient been treated previously for this condition? ☐ Yes ☐ No Medications: _____
Is patient currently on therapy? ☐ Yes ☐ No Medications: _____
Will patient stop taking the above medication(s) before starting the new medication? ☐ 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): _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AFINITOR** ☐ 2.5 mg tab ☐ 5 mg tab ☐ 7.5 mg tab ☐ 10 mg tab
☐ **BOSULIF** ☐ 100 mg tab ☐ 500 mg tab
☐ **GLEEVEC** ☐ 100 mg tab ☐ 400 mg tab
(will dispense combination of 100 mg and 400 mg tab based on patient's dose)
☐ **HYCAMTINE** ☐ 0.25 mg tab ☐ 1 mg tab
☐ **INLYTA** ☐ 1 mg tab ☐ 5 mg tab
(will dispense combination of 1 mg and 5 mg tab based on patient's dose)
☐ **MEKINIST** ☐ 0.5 mg tab ☐ 1 mg tab ☐ 2 mg tab
☐ **NEXAVAR** ☐ 200 mg tab
☐ **NINLARO** ☐ 2.3 mg cap ☐ 3 mg cap ☐ 4 mg cap
☐ **PROMACTA** ☐ 12.5 mg tab ☐ 25 mg tab ☐ 50 mg tab ☐ 75 mg tab ☐ 100 mg tab
☐ **SPRYCEL** ☐ 20 mg tab ☐ 50 mg tab ☐ 70 mg tab ☐ 80 mg tab ☐ 100 mg tab ☐ 140 mg tab
☐ **STIVARGA** ☐ 40 mg tab
☐ **SUTENT** ☐ 12.5 mg cap ☐ 25 mg cap ☐ 50 mg cap ☐ 50 mg po daily for 4 weeks on and 2 weeks off

☐ **TAFINLAR** ☐ 50 mg cap ☐ 75 mg cap
☐ **TARCEVA** ☐ 25 mg tab ☐ 100 mg tab ☐ 150 mg tab
☐ **TASIGNA** ☐ 150 mg cap ☐ 200 mg cap
☐ **TEMOZOLOMIDE** ☐ 5 mg cap ☐ 20 mg cap ☐ 100 mg cap ☐ 140 mg cap ☐ 180 mg cap ☐ 250 mg cap
Total daily dose based on BSA: _____mg POI daily for _____ days off, repeat cycle every _____ days for _____ cycles.
☐ **THALOMID** ☐ 50 mg cap ☐ 100 mg cap ☐ 150 mg cap ☐ 200 mg cap
☐ **TYKERB** ☐ 250 mg tab
☐ **VOTRIENT** ☐ 200 mg tab
☐ **XELODA** ☐ 150 mg tab ☐ 500 mg tab
☐ **XTANDI** ☐ 40 mg cap ☐ 160 mg (four 40 mg caps) po daily ☐ Alternate Dosage _____
☐ **ZYTIGA** ☐ 250 mg tab; 4 times daily (1000 mg)
☐ In combination w/Prednisone 5mg tab BID
☐ Alternate Dosage _____

☐ **OTHER** _____
Dosage: _____
Sig: _____
QTY: _____ Refills: _____

ANTIEMETICS
☐ Chemo-induced N/V ☐ Radiation-induced N/V
☐ **ALOXI** ☐ **EMEND** ☐ **DOLASETRON**
☐ **ONDANSETRON** ☐ **GRANISETRON**
☐ **PROCHLORPERAZINE**
Dosage: _____
QTY: _____ Refills: _____

SUPPORTIVE AGENTS
☐ **NEUPOGEN** ☐ **ARANESP**
☐ **NEULASTA** ☐ **PROCRIT** ☐ **EPOGEN**
Dosage: _____
QTY: _____ Refills: _____

Prescriber's Name / Practice _____ Office Contact _____
Address _____ Suite# _____ City _____ State _____ ZIP _____
Phone _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

By signing this form and utilizing our services, you are authorizing Jersey Shore Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.