MedQuick PHARMACY

Oncology Referral Form

Phone 877.421.3405 Fax 877.421.3406
546 West Las Tunas Drive, San Gabriel, CA 91776

Patient Information

Name (last, first)	Phone ❑Home ❑Cell	Date of Birth

Home Address, City, State	ZIP
Shipping Address, City, State (if different from above)	ZIP

Social Security Number	❑ Male ❑ Female	Allergies

Healthcare Provider Information

Prescriber's First and Last Name	Phone	Fax

Address, City, State	ZIP

Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

Clinical Information

Diagnosis: Date of Diagnosis_______________ Patient Weight __________ kg/lbs

- ❑ 152.9 Gastrointestinal Stromal Tumors
- ❑ 153-154 Metastatic Colorectal Cancer
- ❑ 155.0 Hepatocellular Carcinoma
- ❑ 157.9 Adenocarcinoma of Pancreas
- ❑ 162.9 Pulmonary Malignancy
- ❑ 174 Breast Cancer
- ❑ 189 Renal Cell Cancer
- ❑ 191.9 Glioblastoma
- ❑ 202.1 Cutaneous T-Cell Lymphoma (Mycosis Fungoides)
- ❑ 202.2 Cutaneous T-Cell Lymphoma (Sezary's Disease)
- ❑ 203 Multiple Myeloma
- ❑ 205.1 Chronic Myeloid Leukemia
- ❑ 695.2 Erythema Nodosum (ENL)
- ❑ Other____________________

❑Yes ❑No Has patient been treated previously for this condition?
❑Yes ❑No Is patient currently on therapy?
Current Medications:____
❑Yes ❑No Will patient stop taking above medications before starting new medication?
If yes, what is the washout period?_________________________________
Other medications patient is currently taking including OTC medications with dosage and direction or fax medication profile:____________________________________
____

Physician Orders

❑ Pomalyst ❑Revlimid ❑Thalomid ❑Dexamethasone

Dose:___________ Qty:___________ Directions:______________________________________

❑ Female Child – NOT of Reproductive Potential
❑ Female Child – Reproductive Potential
❑ Male Child
❑ Adult Female – NOT of Reproductive Potential
❑ Adult Female – Reproductive Potential
❑ Adult Male

❑ Zytiga 250mg 4 QD (on empty stomach) Qty:______________ Refill:______________
❑ WITH Prednisone 5 mg BID w/ food Qty:______________ Refill:______________

❑ I V I G

❑ Afinitor	❑ Gilotrif	❑ Sprycel	❑ Tasigna
❑ Arimidex	❑ Gleevec	❑ Sutent	❑ Temodar
❑ Bosulif	❑ Hycamtin	❑ Stivarga	❑ Tykerb
❑ Cometriq	❑ Iclusig	❑ Sylatron	❑ Votrient
❑ Erivedge	❑ Jakafi	❑ Tafinlar	❑ Xeloda
❑ Exjade	❑ Mekinist	❑ Tamoxifen	❑ Xtandi
❑ Femara	❑ Nexavar	❑ Tarceva	❑ Zelboraf
			❑ Zolinza

DOSE/QUANTITY/DIRECTION:

Refill #:_____________

Injectibles

❑ Aranesp ❑ Lovenox ❑ Perjeta
❑ Arixtra ❑ Lupron ❑ Procrit
❑ Fragmin ❑ Neulasta ❑ Sandostatin
❑ Leukine ❑ Nplate

IV Infusion

❑ Avastin ❑ Herceptin
❑ Erbitux ❑ Reclast
❑ Gazyva ❑ Rituxan
❑ Kadcyla

Support Drugs

❑ Emend
❑ Promacta
❑ Sancuso
❑ Zofran

DOSE/QUANTITY/DIRECTION:

Refill #:_____________

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

Physician Signature:____ **Date** ____/____/____

I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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