# ONCOLOGY INFUSION REFERRAL FORM

**MED CENTER Rx SPECIALTY PHARMACY**
*Dedicated to Improving Our Patients' Health*
Part of The Elwyn Pharmacy Group

3100 MacCorkle Avenue S.E. Suite 100
Charleston, WV 25304
TEL: 304-344-8021 | FAX: 304-344-0655

Today's Date

☐ **CURRENT PATIENT**
☐ **NEW PATIENT**

Patient Name _____ SS# _____ DOB _____
Height _____ Weight _____ Address _____ Apt # _____
☐ Male ☐ Female City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

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

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite# _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

**Diagnosis** ☐ Breast Cancer ☐ Renal Cell Carcinoma ☐ Colon Cancer ☐ Colorectal Cancer ☐ Non-small cell lung cancer
☐ Glioblastoma ☐ Chronic Lymphocytic Leukemia ☐ Non-Hodgkin's Lymphoma ☐ Other_____
☐ BCG refractory carcinoma in situ (CIS) of the urinary bladder when immediate cystectomy would be associated with morbidity and mortality
☐ Malignant melanoma, Unresectable or Metastatic ☐ Metastatic gastric or gastroesophageal junction adenocarcinoma
Cancer Stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Other _____
Has patient been treated previously for this condition? ☐ Yes ☐ No (If pt has been on Xeloda, please indicate dose and duration of therapy below)
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**

☐ **ARZERRA** Dosage: _____
QTY: ____ Infusion Cycle(s) Refills:____

☐ **AVASTIN** Dosage: _____
100 mg/4 ml; 400 mg/16 ml QTY: ____ Infusion Cycle(s) Refills:____

☐ **GAZYVA** Dosage: _____
QTY: ____ Infusion Cycle(s) Refills:____

☐ **HERCEPTIN** Dosage: _____
440 mg Multi-dose vial QTY: ____ Infusion Cycle(s) Refills:____

☐ **IXEMPRA** Dosage: 40 mg/m² _____ mg IV over 3 hrs every 3 wks
15 mg; 45 mg vial QTY: ____ Infusion Cycle(s) Refills:____
Other: _____ QTY: ____ Infusion Cycle(s) Refills:____

☐ **KADCYLA** Dosage: _____
QTY: ____ Infusion Cycle(s) Refills:____

☐ **PERJETA** 420 mg/ 14 ml Vial Note: Dilute with NS--- Do NOT use D5W
Initial Dose: 840 mg IV over 60 min Qty: 2 vials Refills: 0
Maintenance Dose: 420 mg IV over 30–60 min every 3 weeks
Other: _____
QTY: ____ Infusion Cycle(s) Refills:____

☐ **RITUXAN** Dosage: _____
100 mg/10 ml; 500 mg/50 ml QTY: ____ Infusion Cycle(s) Refills:____

☐ **YERVOY** 50 mg/10 ml; 200 mg/40 ml
Dosage: 3 mg/kg _____ mg IV over 90 minutes Q 3 weeks for a total of 4 doses Qty: Total of 4 infusion cycle (or one cycle with 3 refills)
Other: _____ QTY: ____ Infusion Cycle(s) Refills:____
*(Note: permanently discontinue if treatment cannot be completed within 16 weeks from administration of first dose)*

☐ **ALIMTA**
☐ **ABRAXANE**
☐ **ADCETRIS**
☐ **CARBOPLATIN**
☐ **CISPLATIN**
☐ **DOCETAXEL**
☐ **ERBITUX**
☐ **GEMCITABINE**
☐ **JEVTANA**
☐ **OXALIPLATIN**
☐ **PACLITAXEL**
☐ **TORISEL**
☐ **VELCADE**
☐ **ZOMETA**

Dosage:_____
_____
Qty: _____
Refills: _____

### COLONY STIMULATING FACTORS:

☐ **NEUPOGEN**
☐ 300 mcg SQ
☐ 480 mcg SQ
☐ Other _____
☐ Daily x_____ days ☐ BIW
☐ Every Week ☐ TIW
☐ **NEULASTA**
☐ **PROCRIT**
☐ **EPOGEN**
☐ 40,000 units SQ weekly
☐ Other:_____
☐ **ARANESP**
☐ **NEUMEGA** 5 mg vial

Dosage: _____
Qty: _____ Refills: _____

### ANTIEMETICS

☐ Chemo-induced N/V ☐ Radiation-induced N/V

☐ **ARZERRA**
☐ **ALOXI**
☐ **DOLASETRON**
☐ **EMEND**
☐ **GRANISETRON**
☐ **ONDANSETRON**
☐ **PROCHLORPERAZINE**

Dosage: _____Qty: _____ Refills: _____

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

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



Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit **WWW.MEDCENTERSPECIALTYPHARMACY.COM** for online fillable forms.

# NEW REFERRAL CHECKLIST

## PLEASE USE THIS CHECKLIST FOR ONCOLOGY PATIENTS

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment. All lab reports (or EMR) must contain the following information within the last 30 days.

***Please forward any updates to us you receive from the insurance company regarding approvals or denials***

### REQUIRED INFORMATION:

- ☐ Patient name
- ☐ Patient Demographics (Address, Phone Number, DOB, etc…)
- ☐ Medication list and allergies
- ☐ Insurance information with RX insurance. Please include copy of card.
  If the only card included is a medical card, please include local pharmacy information.
- ☐ MD name/NPI/Office contact/Phone number
- ☐ Drug indicated with refills
- ☐ MD signature and date on referral form
- ☐ Diagnosis Code
- ☐ Previous therapies listed
- ☐ Concurrent medications for same diagnosis
- ☐ Quantity, frequency and cycle of medication


*Fax the requested documentation to (304) 344-0655*

*Toll Free: 1-855-633-5633  Direct Phone: (304) 344-8021*

*MedCenterSpecialtyPharmacy.com*

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