ONCOLOGY INFUSION REFERRAL FORM

Dedicated to Improving Our Patients' Health

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Garnet Valley, PA 19060
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Toll Free: 866-317-0672

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** ☐ **GRANISETRON**
☐ **ALOXI** ☐ **ONDANSETRON**
☐ **DOLASETRON** ☐ **PROCHLORPERAZINE**
☐ **EMEND**
Dosage: ______ Qty: ______ Refills: ______

By signing this form and utilizing our services, you are authorizing Elwyn Specialty Care 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**______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **www.ELWYNSPECIALTYCARE.com** for online fillable forms.

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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 (610) 545-6030

Toll Free: 1-855-ELWYN-RX (359-9679) Direct Phone: (610) 545-6040

ElwynSpecialtyCare.com

Elwyn SPECIALTY CARE Rx

Part of The Elwyn Pharmacy Group

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