Elwyn SPECIALTY CARE
A BioMatrix Company

FEB 2018

ORAL ONCOLOGY REFERRAL FORM

3070 McCann Farm Drive | Suite 101
Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

☐ CURRENT PATIENT
☐ NEW PATIENT

Patient Name _____ SS# _____ DOB _____
Height _____ Weight _____ BSA _____ 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 Local Pharmacy Phone _____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION

REFERRAL SOURCE INFORMATION

☐ _____ # _____	☐ _____ # _____	☐ _____ # _____
☐ _____ # _____	☐ _____ # _____	☐ _____ # _____
☐ _____ # _____	☐ _____ # _____	☐ _____ # _____
☐ _____ # _____	☐ _____ # _____	☐ _____ # _____
☐ _____ # _____	☐ _____ # _____	☐ _____ # _____

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# _____

Diagnosis ICD-10:_____ Cancer Stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Other _____
Has patient been treated previously for this condition? ☐ Yes ☐ No (If patient 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? _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AFINITOR tablets** ☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg
Sig: _____ Qty: _____ Refills: _____

☐ **BOSULIF tablets** ☐ 100 mg ☐ 500 mg
Sig: _____ Qty: _____ Refills: _____

☐ **CAPECITABINE** ☐ 150 mg ☐ 500 mg
Sig: _____ Qty: _____ Refills: _____

☐ **GLEEVEC tablets** ☐ 100 mg ☐ 400 mg
Sig: _____ Qty: _____ Refills: _____

☐ **HYCAMTIN tablets** ☐ 0.25 mg ☐ 1 mg
Sig: _____ Qty: _____ Refills: _____

☐ **IBRANCE capsules** ☐ 75 mg ☐ 100 mg ☐ 125 mg
Sig: _____ Qty: _____ Refills: _____

☐ **IMBRUVICA capsules** ☐ 140 mg
Sig: _____ Qty: _____ Refills: _____

☐ **INLYTA tablets** ☐ 1 mg ☐ 5 mg
Sig: _____ Qty: _____ Refills: _____

☐ **MEKINIST tablets** ☐ 0.5 mg ☐ 2 mg
Sig: _____ Qty: _____ Refills: _____

☐ **PROMACTA tablets** ☐ 12.5 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg ☐ 100 mg
Sig: _____ Qty: _____ Refills: _____

☐ **SPRYCEL tablets** ☐ 20 mg ☐ 50 mg ☐ 70 mg ☐ 80 mg ☐ 100 mg ☐ 140 mg
Sig: _____ Qty: _____ Refills: _____

☐ **KISQALI 200mg tablets**
Sig: Take ☐ 600 mg ☐ 400 mg ☐ 200 mg by mouth daily for 21 days followed by a 7 day rest period
(must be administered in combination with other aromatase inhibitor)
Qty: ☐ 21 (200mg QD) ☐ 42 (400mg QD) ☐ 63 (600mg QD) Refills: _____

☐ **SUTENT** ☐ 12.5 mg CAP ☐ 25 mg CAP ☐ 50 mg CAP
Sig: _____ Qty: _____ Refills: _____

☐ **TAFINLAR capsules** ☐ 50 mg ☐ 75 mg
Sig: _____ Qty: _____ Refills: _____

☐ **TARCEVA tablets** ☐ 25 mg ☐ 100 mg ☐ 150 mg
Sig: _____ Qty: _____ Refills: _____

☐ **TASIGNA capsules** ☐ 150 mg ☐ 200 mg
Sig: _____ Qty: _____ Refills: _____

☐ **TEMOZOLOMIDE capsules** ☐ 5 mg ☐ 20 mg ☐ 100 mg ☐ 140 mg ☐ 180 mg ☐ 250 mg
Sig: _____ Qty: _____ Refills: _____

☐ **THALOMID capsules** ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg
Sig: _____ Qty: _____ Refills: _____

☐ **TYKERB tablets** ☐ 250 mg
Sig: _____ Qty: _____ Refills: _____

☐ **VOTRIENT tablets** ☐ 200 mg
Sig: _____ Qty: _____ Refills: _____

☐ **XTANDI capsules** ☐ 40 mg
Sig: _____ Qty: _____ Refills: _____

☐ **ZYTIGA tablets** ☐ 250 mg; 4 tablets daily (1000 mg)
☐ Local Pharmacy providing Prednisone
☐ Please provide Prednisone 5mg BID
Sig: _____ Qty: 60 Refills: _____

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

OTHER _____
Dosage: _____ Qty: _____ Refills: _____
Sig: _____

▬ = Restricted access medication as of June 2017

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**_____

Please fax completed referral form to **Elwyn Specialty Care** at **610-545-6030** Visit **www.ELWYNSPECIALTYCARE.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 (610) 545-6030

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

ElwynSpecialtyCare.com

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