

ONCOLOGY PRESCRIPTION REFERRAL FORM

54 Conchester Road Glen Mills, PA 19342
 1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-9 Diagnosis Code _____ Weight _____ Allergies _____ BSA _____ m²
 Biopsy Yes No Results _____ Patient currently on therapy Yes No Date of next blood work _____

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# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

<input type="checkbox"/> Afinitor	<input type="checkbox"/> Sutent	<input type="checkbox"/> Votrient 200mg	<input type="checkbox"/> Antiemetics	<input type="checkbox"/> Chemo-induced N/V
<input type="checkbox"/> Arimidex	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Zoladex	<input type="checkbox"/> Compazine	<input type="checkbox"/> Emend
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Tamoxifen	<input type="checkbox"/> Zolanza	<input type="checkbox"/> Zofran	<input type="checkbox"/> Sancuso Transdermal Patch
<input type="checkbox"/> Etoposide	<input type="checkbox"/> Tarceva	<input type="checkbox"/> Xeloda	Dosage _____ QTY _____ Refills _____	
<input type="checkbox"/> Gleevec	<input type="checkbox"/> Tasisna	<input type="checkbox"/> Zytiga	<input type="checkbox"/> Neupogen	<input type="checkbox"/> 300 mcg SQ <input type="checkbox"/> 480 mcg SQ <input type="checkbox"/> Other _____ QTY _____ Refills _____
<input type="checkbox"/> Herceptin	<input type="checkbox"/> Temodar	<input type="checkbox"/> _____	<input type="checkbox"/> Neulasta	<input type="checkbox"/> Daily x _____ days <input type="checkbox"/> Every week <input type="checkbox"/> BIW <input type="checkbox"/> TIW QTY _____ Refills _____
<input type="checkbox"/> Hycamtin	<input type="checkbox"/> Thalomid	<input type="checkbox"/> _____	<input type="checkbox"/> Procrit	<input type="checkbox"/> 40,000 units SQ Weekly <input type="checkbox"/> Other _____ QTY _____ Refills _____
<input type="checkbox"/> Nexavar	<input type="checkbox"/> Tykerb 250mg	<input type="checkbox"/> _____	<input type="checkbox"/> Aranesp	Dosage _____ QTY _____ Refills _____
Strength _____			<input type="checkbox"/> Neumega 5mg vial	Dosage _____ QTY _____ Refills _____
SIG _____			<input type="checkbox"/> Other	QTY _____ Refills _____
QTY _____ Refills _____				

By signing this form and utilizing our services, you are authorizing Elwyn Specialty and its 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** _____

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