



PharmaCare Specialty Pharmacy Oncology Referral Form

FAX REFERRAL TO: 800-447-3694
Phone: 800-990-9247

Date: _____ **Needs by Date:** _____ •Ship to Patient Office Inj. Training at PharmaCare

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 Patient SS#: _____
 Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ DEA#: _____
 Group or Hospital: _____
 Address: _____
 City, State, Zip: _____
 Phone: _____
 Fax: _____
 Contact Person: _____

INSURANCE INFORMATION

Primary Insurance/
Prescription Card:

PLEASE FAX COPY OF CARD
(FRONT & BACK)

Secondary Insurance/
Prescription Card:

PLEASE FAX COPY OF CARD
(FRONT & BACK)

CLINICAL INFORMATION

(OPTIONAL – but will assist in insurance authorization and patient education)

Diagnosis (ICD-9 code):

_____ _____
 _____ _____

Other Clinical Info/Lab Data *(if applicable)*:

• Weight: _____ kg or _____ lbs
 • Hgb/Hct: _____ / _____ WBC: _____ ANC: _____

PRESCRIPTION INFORMATION

ORAL TREATMENTS / ANTIEMETICS:

MEDICATION	STRENGTH	SIG/DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Gleevec®				
<input type="checkbox"/> Nexavar®				
<input type="checkbox"/> Sprycel®				
<input type="checkbox"/> Sutent®				
<input type="checkbox"/> Tarceva®				
<input type="checkbox"/> Temodar®				
<input type="checkbox"/> Thalomid®				
<input type="checkbox"/> Xeloda®				
<input type="checkbox"/> _____				
<input type="checkbox"/> Zofran®				
<input type="checkbox"/> Kytril®				

INJECTABLES / BLOOD MODIFICATION:

MEDICATION	STRENGTH	SIG/DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Aranesp®				
<input type="checkbox"/> Faslodex®				
<input type="checkbox"/> Intron®				
<input type="checkbox"/> Lovenox®				
<input type="checkbox"/> Neulasta®				
<input type="checkbox"/> Neupogen®				
<input type="checkbox"/> Procrit®				
<input type="checkbox"/> _____				

Do not Substitute

Prescriber Signature

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