LIFECARE PHARMACY

www.lifecarepharmacy.com

Oncology Referral Form

Surescripts ID #:

Office #: 1-210-881-0890
Fax #: 1-210-569-6464

Referral Info

PATIENT INFORMATION

PATIENT NAME		**SSN #:**		**DOB:**	
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**	
HOME PHONE:	**CELL PHONE:**	**HEIGHT:**	**WEIGHT:**	**GENDER:**	**MALE FEMALE**
Email ADDRESS:		**DIAGNOSIS CODE:**			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

REVLIMID®

Dosing:
o5 mg o10 mg
o15 mg o25 mg

Directions:
o Take_____caps by mouth once a day on days 1-21, of a 28-day cycle.

Qty: _____ No Refills

THALOMID®

Dosing:
o50 mg o100 mg
o150 mg o200 mg

Directions:
o Take_____caps by mouth once daily at bedtime.

Qty: _____ No Refills

POMALYST®

Dosing:
o1 mg o2 mg
o3 mg o4 mg

Directions:
O Take_____caps by mouth once daily at bedtime.

Qty: _____ No Refills

Female
- o adult Female, Not of Reproductive Potential
- o adult Female, Reproductive Potential
- o Female Child, Not of Reproductive Potential
- o Female Child, Reproductive Potential

Male
o adult male o male Child

Celgene auth #: _____
Date issued: _____
Confirmation #: _____
Date issued: _____

CAPECITABINE (XELODA)

Dosing:
o150 mg o 500 mg
o Take tabs by mouth two times a day on days 1-14 of 21-day cycle. Repeat.
O Conjunction with radiation: Start Date: for _____# of days a week.
O Other _____

Qty: _____ No Refills

TEMOZOLOMIDE (TEMODAR)

Dosing:
o_____mg
o Take_____mg by mouth daily for _____days with _____ days off
o Conjunction with radiation: Start Date: for_____# of days a week.
O Other _____

Qty: _____ No Refills

IMATINIB (GLEEVEC)

Dosing:
o100 mg o 400 mg
o Take tabs by mouth once a day
o Other _____

Qty: _____ No Refills

- ❑ AFINITOR®
- ❑ ARANESP®
- ❑ AVASTIN®
- ❑ BOSULIF®
- ❑ DAURISMO™
- ❑ ERLEADA™
- ❑ FARYDAK®
- ❑ HERCEPTIN®
- ❑ IBRANCE®
- ❑ LETROZOLE
- ❑ INLYTA®
- ❑ JADENU™
- ❑ KADCYLA™
- ❑ KEYTRUDA®
- ❑ KISQALI®
- ❑ LORBRENA®
- ❑ MEKINIST™
- ❑ NEULASTA®
- ❑ NEUPOGEN®
- ❑ NINLARO®
- ❑ ODOMZO®
- ❑ OPDIVO®
- ❑ PERJETA™
- ❑ PROCRIT®
- ❑ RITUXAN®
- ❑ RYDAPT®
- ❑ SPRYCEL®
- ❑ SUTENT®
- ❑ SYLATRON®
- ❑ TAFINLAR®
- ❑ TARCEVA®
- ❑ TALZENNA®
- ❑ TARGRETIN®
- ❑ TASIGNA®
- ❑ TYKERB®
- ❑ VIZIMPRO®
- ❑ VOTRIENT®
- ❑ XALKORI®
- ❑ YONSA
- ❑ ZYTIGA®
- ❑ ZOLINZA™
- ❑ ZYKADIA™

***Please use this section for additional directions or other medications not listed. ***

▪ OTHER

STRENGTH:

SIG/DIRECTIONS

QUANTITY:	REFILLS:
Start of Therapy Date:	Special Delivery Instructions:

PHYSICIAN INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Office Contact/Faxed by:	**Email:**	
NPI#:	**TAXID#:**	**Ship To: O Patient O MD 1ST Fill Only O MD All Orders**
Prescriber Signature:		
○ **Dispense as written**	**Date**	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

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