ACCUSERV PHARMACY

ONCOLOGY REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Start Date:

Ship To: ☐ Patient ☐ Office ☐ Other

1. Patient Information:

Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: ____________ ____________ (First Name, Last Name) Male / Female DOB: ________ Soc. Sec. #____________

Address: ____________ ____________ ____________ ____________ (Street, City, State, Zip)

Primary phone number: ____________ Alternate phone number: ____________

Caregiver: ____________ Allergies: ____________

Comorbidities: ____________ Height: ________ Weight: ________

2. Clinical Information:

Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior ÁÕÔÈÏÒÉÚÁÔÉÏÎ

Diagnosis/ICD-10 (C00-D49) ____________

Patient Type (if applicable):

☐ adult female NOT of reproductive potential ☐ child female NOT of reproductive potential

☐ adult female of reproductive potential ☐ child female of reproductive potential Date: ____________

BRAF mutation present (if applicable): ☐ V600E ☐ V600K Any prior treatment: ☐ No ☐ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: ____________

Concomitant Medications: ____________

Allergies: ☐ NKDA ☐ Other: ____________

3. Prescription Information:

If you need a medication not listed please contact us

Oncolytics:

☐ Afinitor® ☐ Folotyn® ☐ Lupron® ☐ Tabloid® ☐ Votrient®

☐ Arimidex® ☐ Gleevec® ☐ Lysodren® ☐ Tamoxifen® ☐ Xeloda®

☐ Emcyt® ☐ Hycamtin® ☐ Matulane® ☐ Targretin® ☐ Yervoy®

☐ Empliciti® ☐ Intron A® ☐ Opdivo® ☐ Tasigna® ☐ Zolinza®

☐ Etoposide® ☐ Keytruda® ☐ Sprycel® ☐ Temodar ☐ Zykadia™

☐ Femara® ☐ Lomustine® (Ceenu®) ☐ Sylatron® ☐ Tykerb® ☐ Other:

Strength/Directions (SIG):

Refill # :

Strength/Directions (SIG):

Refill # : **QTY:**

BRAF mutation present:

☐ Mekinist® ☐ V600E

☐ Tafinlar® ☐ V600K

Authorization # :

☐ **AccuPac**

Supportive Medications:

☐ Aranesp® ☐ Granix® ☐ Neupogen® ☐ Promacta® ☐ Zofran®

☐ Arixtra® ☐ Lovenox® ☐ Nplate® ☐ Sancuso® ☐ Other:

☐ Emend® ☐ Neulasta® ☐ Procrit® ☐ Zarxio®

Strength/Directions (SIG):

Refill # : **QTY:**

Strength(s): ____________ Directions: ____________

Quantity: ____________ Refills: ____________ **Authorization: ____________

Packaging: ☐ Normal ☐ AccuPac™

4. Prescriber and Shipping Information

Prescriber (print)____________ **Office Contact:**____________

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**____________

Office Address:____________

Phone:____________ **fax:**____________ **NPI:**____________ **DEA:**____________

Prescriber's Signature: ____________ **Date:**____________

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process (NO STAMPS)

5. Patient Support Programs (optional):

Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: **Date:**

6. Insurance Information:

Please fax a copy of the insurance card (front & back)