Across Specialty Pharmacy

# ONCOLOGY REFERRAL FORM (A-T)

PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Last Name | First Name | DOB | Gender ☐ M ☐ F | Last 4 SSN | Primary Language |
| Address | | City | State | ZIP | |
| Email | Home Phone | Work Phone | Cell Phone | | |
| Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT | | | | | |
| Primary Caregiver/Alt Contact Name (If applicable) | Alt Contact Email | Alt Contact Phone | | | |

## PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Name of Contact Sending Referral | Title | Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax | |
| Referral Contact Email | Office Phone | Office Fax | |
| Practice / Facility Name | Prescriber Name / Specialty | | |
| Address | City | State | ZIP |
| Prescriber State License # | DEA # | NPI # | Medicaid UPIN # |

## CLINICAL INFORMATION

| | |
|---|---|
| Patient New to Therapy ☐ Yes ☐ No, Start Date of Current Therapy: | Date Medication Needed |
| Treatment History or Failed Therapies (Please also attach recent labs/clinical notes) | |
| Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: | Patient Height (cm/in): Weight (kg/lbs): Date Obtained: |
| Other/Concomitant Medications (please list) | |
| Allergies ☐ NKDA ☐ Drug Allergies (please list) | |
| Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list) | |
| ICD-10 Code ☐ Code: Description: | |

## PRESCRIPTION INFORMATION

### Oral Oncology Agents

| | | | | | |
|---|---|---|---|---|---|
| ☐ Abiraterone Acetate | ☐ Braftovi | ☐ Fareston | ☐ Inrebic | ☐ Mektovi | ☐ Rezurock |
| ☐ Afinitor | ☐ Capecitabine | ☐ Farydak | ☐ Jakafi | ☐ Mercaptopurine | ☐ Rydapt |
| ☐ Afinitor Disperz | ☐ Daurismo | ☐ Femara | ☐ Kisqali | ☐ Mesnex | ☐ Scemblix |
| ☐ Alkeran | ☐ Emcyt | ☐ Gavreto | ☐ Kisqali + Femara Co-Pack | ☐ Methotrexate | ☐ Soltamox |
| ☐ Anastrozole | ☐ Erivedge | ☐ Gleevec | ☐ Lapatinib | ☐ Mylotarg | ☐ Sorafenib |
| ☐ Arimidex | ☐ Erleada | ☐ Gleostine | ☐ Lenvima | ☐ Nilandron | ☐ Sprycel |
| ☐ Aromasin | ☐ Erlotinib | ☐ Hycamtin | ☐ Letrozole | ☐ Nilutamide | ☐ Sunitinib Malate |
| ☐ Besponsa | ☐ Etoposide | ☐ Hydroxyurea | ☐ Leucovorin | ☐ Nolvadex | ☐ Sutent |
| ☐ Bexarotene | ☐ Everolimus | ☐ Ibrance | ☐ Leukeran | ☐ Odomzo | ☐ Tabrecta |
| ☐ Bicalutamide | ☐ Everolimus Soluble | ☐ Imatinib Mesylate | ☐ Lorbrena | ☐ Onureg | ☐ Tafinlar |
| ☐ Bosulif | ☐ Exemestane | ☐ Inlyta | ☐ Mekinist | ☐ Piqray | ☐ Talzenna |

Dose: _____ ☐ Tablets ☐ Capsules ☐ Other: _____ Qty: _____ Refills: _____

Directions: _____

### BMS Rems Products

REVLIMID ☐2.5 mg ☐5 mg ☐10 mg ☐15 mg ☐20 mg ☐25 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily. | QTY: 28 | 0 Refills |
| ☐ Take 1 capsule PO daily; days 1-21 of 28-day cycle. | QTY: 21 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

THALOMID ☐50 mg ☐100 mg ☐150 mg ☐200 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily. | QTY: 28 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

POMALYST ☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily, days 1-21 of 28-day cycle. | QTY: 21 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

Risk Category

☐ ADULT Female, NOT of Reproductive Potential
☐ ADULT Female, Reproductive Potential
☐ ADULT Male
☐ Female CHILD, NOT of Reproductive Potential
☐ Female CHILD, Reproductive Potential
☐ Male CHILD

Celgene Auth #: _____
Date Issued: _____
Confirmation #: _____
Date Issued: _____

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____

Across Specialty Pharmacy

# ONCOLOGY REFERRAL FORM (T-Z)

PH (770) 746 0130 | FAX (770) 746 0131
NCPDP 1175288 | NPI 1275142614

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Last Name | First Name | DOB | Gender ☐ M ☐ F | Last 4 SSN | Primary Language |
| Address | | City | State | ZIP | |
| Email | Home Phone | Work Phone | Cell Phone | | |
| Primary Contact Method (check one) ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT | | | | | |
| Primary Caregiver/Alt Contact Name (If applicable) | Alt Contact Email | Alt Contact Phone | | | |

## PRESCRIBER INFORMATION

| | | | | |
|---|---|---|---|---|
| Name of Contact Sending Referral | Title | Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax | | |
| Referral Contact Email | Office Phone | Office Fax | | |
| Practice / Facility Name | Prescriber Name / Specialty | | | |
| Address | City | State | ZIP | |
| Prescriber State License # | DEA # | NPI # | Medicaid UPIN # | |

## CLINICAL INFORMATION

| | | | | |
|---|---|---|---|---|
| Patient New to Therapy ☐ Yes ☐ No, Start Date of Current Therapy: | Date Medication Needed | | | |
| Treatment History or Failed Therapies (Please also attach recent labs/clinical notes) | | | | |
| Sample/Starter Provided? ☐ No ☐ Yes, Provide Qty: Date Provided: | Patient Height (cm/in): Weight (kg/lbs): Date Obtained: | | | |
| Other/Concomitant Medications (please list) | | | | |
| Allergies ☐ NKDA ☐ Drug Allergies (please list) | | | | |
| Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list) | | | | |
| ICD-10 Code ☐ Code: Description: | | | | |

## PRESCRIPTION INFORMATION

### Oral Oncology Agents

| | | |
|---|---|---|
| ☐ Tarceva | ☐ Xeloda | ☐ Other: |
| ☐ Targretin | ☐ Xtandi | ☐ Other: |
| ☐ Tasigna | ☐ Xatmep | ☐ Other: |
| ☐ Temodar | ☐ Yonsa | ☐ Other: |
| ☐ Temozolomide | ☐ Zolinza | ☐ Other: |
| ☐ Toremifene Citrate | ☐ Zykadia | ☐ Other: |
| ☐ Tretinoin | ☐ Zytiga | ☐ Other: |
| ☐ Tykerb | ☐ Other: | |
| ☐ Vizimpro | ☐ Other: | |
| ☐ Votrient | ☐ Other: | |
| ☐ Xalkori | ☐ Other: | |

Dose:_____ ☐ Tablets ☐ Capsules ☐ Other:_____ Qty:_____ Refills:_____

Directions: _____

### BMS Rems Products

REVLIMID ☐2.5 mg ☐5 mg ☐10 mg ☐15 mg ☐20 mg ☐25 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily. | QTY: 28 | 0 Refills |
| ☐ Take 1 capsule PO daily; days 1-21 of 28-day cycle. | QTY: 21 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

THALOMID ☐50 mg ☐100 mg ☐150 mg ☐200 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily. | QTY: 28 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

POMALYST ☐1 mg ☐2 mg ☐3 mg ☐4 mg

| | | |
|---|---|---|
| ☐ Take 1 capsule PO once daily, days 1-21 of 28-day cycle. | QTY: 21 | 0 Refills |
| ☐ Other: _____ | QTY: _ | 0 Refills |

Risk Category

☐ ADULT Female, NOT of Reproductive Potential
☐ ADULT Female, Reproductive Potential
☐ ADULT Male
☐ Female CHILD, NOT of Reproductive Potential
☐ Female CHILD, Reproductive Potential
☐ Male CHILD

Celgene Auth #: _____
Date Issued: _____
Confirmation #: _____
Date Issued: _____

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ Prescriber Signature
_____ Date
_____ Supervising Physician Signature (where required by state law)
_____ Date

_____ DAW (Dispense as Written)
_____ Date
_____ Brand Necessary (must handwrite)