BioPlus® Specialty Pharmacy
A Carelon Company

E-prescribe the *Fast & Easy* way: select **BioPlus** from your EHR!
Fax: 800-269-5493
Phone: 833-ONC- EASY (662-3279)
bioplusrx.com

ORAL ONCOLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		SSN:		DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell:	Height:	Weight:	Gender: ◯ Male ◯ Female
Email:		Allergies:		
Primary Diagnosis:		Secondary Diagnosis (ICD-10)		

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of prescription)

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
REVLIMID® *(lenalidomide)†* *Complete lab section below*	☐ 2.5 mg ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg	☐ Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle. ☐ Take _____ caps by mouth once a day on days 1-14, of a 21 day cycle. ☐ Take _____ caps by mouth once a day on days 1-14, of a 28 day cycle ☐ Take _____ caps by mouth once a day continuously on days 1-28.		None
THALOMID® *(thalidomide)*	☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg	☐ Take _____ caps by mouth once daily at bedtime.		None
POMALYST®*(pomalidomide)*	☐ 1 mg ☐ 2 mg ☐ 3 mg ☐ 4 mg	☐ Take _____ caps by mouth once daily on days 1-21, of a 28 day cycle.		None

Patient Type: ☐ Adult Female, Not of Reproductive Potential ☐ Adult Female, Reproductive Potential ☐ Female Child, Not of Reproductive Potential ☐ Female Child, Reproductive Potential ☐ Adult Male ☐ Male Child

Celgene Auth#: _____ **Date Issued:** _____

† To prevent delays and minimize phone calls please provide the following labs: Serum Creatinine: eGFR/CrCL: Date:

XELODA® *(capecitabine)* †Complete lab section above*	☐ 150 mg ☐ 500 mg Total dose: _____mg	☐ Take total dose by mouth twice daily on days 1-14 of 21 day cycle. Repeat. ☐ Take total dose twice daily in conjunction with radiation: ☐ M-F ☐ 7 days/week Radiation length of therapy:_____ ☐ Other_____		
TEMODAR® *(temozolomide)**	☐ Total dose: _____mg tablet	☐ Take _____ mg by mouth once daily for 5 days every 28 days ☐ Take _____ mg by mouth once daily in conjunction with radiation for _____ days State Date _____ for _____# of days a week ☐ Other_____		
Deferiprone	500 mg tablet	☐ Take _____mg by mouth three times daily with or without food Recommended dosing 25 mg/kg to 33mg/kg body weight three time a day. Total daily dose of 75mg/kg to 99mg/kg		
JADENU™ *(deferasirox)* †*☐ Tablets ☐ Sprinkle Granules	☐ 90 mg ☐ 180 mg ☐ 360 mg	☐ Take _____mg by mouth once daily with or without a light meal.		
EXJADE® *(deferasirox)* †*Tablets for Suspension	☐ 125 mg ☐ 250 mg ☐ 500 mg	☐ Take _____mg by mouth once daily on an empty stomach at least 30 minutes before food		
ZYTIGA®*(abiraterone acetate)**	☐ 250 mg ☐ 500 mg	☐ Take _____mg by mouth once daily.		
with PREDNISONE	_____mg	☐ CRPC: Take 5 mg by mouth twice daily with food ☐ CSPC: Take 5 mg by mouth once daily with food		
Sorafenib	200 mg tablets	400 mg (2 tablets) orally twice daily without food		

AFINITOR® *(everolimus)**
AGRYLIN® *(anagrelide)**
ALECENSA® *(alectinib)*
BESPONSA® *(inotuzumab ozogamicin)*
BOSULIF® *(bosutinib)* †
BRAFTOVI® *(encorafenib)*
COTELLIC® *(cobimetinib)*
CYTOXAN® *(cyclophosphamide)**
DAURISMO™ *(glasdegib)*
ERIVEDGE™*(vismodegib)*
ERLEADA™*(apalutamide)*
FASLODEX *(fulvestrant)**
FEMARA® *(letrozole)**
FORTEO® *(teriparatide)*
GAVRETO® *(pralsetinib)*
GLEEVEC® *(imatinib)*†*
IBRANCE® *(palbociclib)*
INLYTA® *(axitinib)*
KISQALI® *(ribociclib)**
LORBRENA® *(lorlatinib)†*
LENVIMA® *(lenvatinib)*
MEKINIST™ *(trametinib)*
MEKTOVI® *(binimetinib)*
MYLOTARG™ *(gemtuzumab ozogamicin)*
NILANDRON® *(nilutamide)*
ODOMZO® *(sonidegib)*
ONUREG ® *(azacitidine)*
PIQRAY® *(alpelisib)*
ROZLYTREK® *(entrectinib)*
RYDAPT® *(midostaurin)*
SPRYCEL® *(dasatinib)*
SUTENT® *(sunitinib malate)*
TAFINLAR®*(dabrafenib)*
TALZENNA® *(talazoparib)*
TARCEVA® *(erlotinib)**
TARGRETIN® *(bexarotene)**
TASIGNA® *(nilotinib)*
TYKERB® *(lapatinib)**
VIZIMPRO® *(dacomitinib)*
VOTRIENT® *(pazopanib)*
XALKORI® *(crizotinib)†*
XTANDI® *(enzalutamide)*
YONSA®(abiraterone acetate)
ZELBORAF® *(vemurafenib)*
ZOLINZA™ (vorinostat)

*AVAILABLE IN GENERIC

Drug Name *(write in one of the above)*: _____
☐ Dose: _____ Frequency: _____ Quantity: _____ Refills: _____

Drug Name *(write in one of the above)*: _____
☐ Dose: _____ Frequency: _____ Quantity: _____ Refills: _____

Start of Therapy Date: **Ship To:** ☐ Patient ☐ MD Office

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

Your signature authorizes BioPlus Specialty Pharmacy Services,LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, Route 300 Pharmacy, and Santa Barbara Specialty Pharmacy (the "BioPlus Pharmacies"), to act on your behalf to obtain prior authorization, including appeals and peer to peer reviews, for the prescribed medications We will also pursue available copay and financial assistance on behalf of your patients.
BioPlus Specialty Pharacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct., Suite 100, Morrisville, NC 27560 **BioPlus Specialty Pharmacy** 13925 Yale Ave, Suite145, Irvine, CA 92620
MedScripts Medical Pharmacy 1325 Miller Rd., Suite K, Greenville, SC 29607 **River Medical Pharmacy** 4752 Research Drive, San Antonio, TX 78240 **Route 300 Pharmacy** 1208 Route 300, Suite 103, Newburgh, NY 12550
Santa Barbara Specialty Pharmacy 4690 Carpinteria Ave, Ste B, Carpinteria, CA 93013

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