

Oncology Referral Form

Surecripts ID #:
CPR10785350213549930
Office: 1-888-292-0744
Fax Referral #:
1-800-269-5493

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:		State:	
Home Phone:		Cell Phone:		Height:	
				Weight:	
Email Address:				Gender: Male Female	
				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: <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 25 mg Directions: <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle. Qty: _____ No Refills	THALOMID® Dosing: <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> 150 mg <input type="checkbox"/> 200 mg Directions: <input type="checkbox"/> Take _____ caps by mouth once daily at bedtime. Qty: _____ No Refills	POMALYST® Dosing: <input type="checkbox"/> 1 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> 3 mg <input type="checkbox"/> 4 mg Directions: <input type="checkbox"/> Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle. Qty: _____ No Refills	Female <input type="checkbox"/> Adult Female, Not of Reproductive Potential <input type="checkbox"/> Adult Female, Reproductive Potential <input type="checkbox"/> Female Child, Not of Reproductive Potential <input type="checkbox"/> Female Child, Reproductive Potential Male <input type="checkbox"/> Adult Male <input type="checkbox"/> Male Child Celgene Auth #: _____ Date Issued: _____ Confirmation #: _____ Date Issued: _____
CAPECITABINE (XELODA) Dosing: <input type="checkbox"/> 150 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> Take _____ tabs by mouth two times a day on days 1-14 of 21 day cycle. Repeat. <input type="checkbox"/> Conjunction with radiation: Start Date: _____ for _____ # of days a week. <input type="checkbox"/> Other _____ Qty: _____ Refills: _____	TEMOZOLOMIDE (TEMODAR) Dosing: <input type="checkbox"/> _____ mg <input type="checkbox"/> Take _____ mg by mouth daily for _____ days with _____ days off <input type="checkbox"/> Conjunction with radiation: Start Date: _____ for _____ # of days a week. <input type="checkbox"/> Other _____ Qty: _____ Refills: _____	IMATINIB (GLEEVEC) Dosing: <input type="checkbox"/> 100 mg <input type="checkbox"/> 400 mg <input type="checkbox"/> Take _____ tabs by mouth once a day <input type="checkbox"/> Other _____ Qty: _____ Refills: _____	

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

<input type="checkbox"/> AFINITOR® <input type="checkbox"/> MEKINIST™ <input type="checkbox"/> TARGRETIN® <input type="checkbox"/> ARANESP® <input type="checkbox"/> NEULASTA® <input type="checkbox"/> TASIGNA® <input type="checkbox"/> AVASTIN® <input type="checkbox"/> NEUPOGEN® <input type="checkbox"/> TYKERB® <input type="checkbox"/> BOSULIF® <input type="checkbox"/> NINLARO® <input type="checkbox"/> VIZIMPRO® <input type="checkbox"/> DAURISMO™ <input type="checkbox"/> ODOMZO® <input type="checkbox"/> VOTRIENT® <input type="checkbox"/> ERLEADA™ <input type="checkbox"/> OPDIVO® <input type="checkbox"/> XALKORI® <input type="checkbox"/> FARYDAK® <input type="checkbox"/> PERJETA™ <input type="checkbox"/> YONSA <input type="checkbox"/> HERCEPTIN® <input type="checkbox"/> PROCRI™ <input type="checkbox"/> ZYTIGA® <input type="checkbox"/> IBRANCE® <input type="checkbox"/> RITUXAN® <input type="checkbox"/> ZOLINZA™ <input type="checkbox"/> LETROZOLE <input type="checkbox"/> RYDAPT® <input type="checkbox"/> ZYKADIA™ <input type="checkbox"/> INLYTA® <input type="checkbox"/> SPRYCEL® <input type="checkbox"/> JADENU™ <input type="checkbox"/> SUTENT® <input type="checkbox"/> KADCYLA™ <input type="checkbox"/> SYLATRON® <input type="checkbox"/> KEYTRUDA® <input type="checkbox"/> TAFINLAR® <input type="checkbox"/> KISQALI® <input type="checkbox"/> TARCEVA® <input type="checkbox"/> LORBRENA® <input type="checkbox"/> TALZENNA®	<input type="checkbox"/> OTHER STRENGTH: SIG/DIRECTIONS QUANTITY: _____ REFILLS: _____ Start of Therapy Date: _____ Special Delivery Instructions: _____
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PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact/Faxed By:	Email:	
NPI#:	TAX ID#:	Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office 1st Order Only <input type="checkbox"/> MD Office All Orders
Prescriber Signature	Date:	
<input type="checkbox"/> Dispense as written		

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.

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

RxExpress 2-Day Ready 2 Ship:
Receive all the benefits of our fast and easy express service, including our NEW 2-Day Ready 2 Ship, for all eligible prescriptions.

BioPlus Specialty Pharmacy
376 Northlake Blvd., Altamonte Spings, FL 32701

RxExpress
2-Day Ready 2 Ship

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