BioPlus® Specialty Pharmacy
www.bioplusrx.com

Oncology Referral Form

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

Referral Info

PATIENT INFORMATION

Patients 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:
❏2.5 mg ❏5 mg ❏10 mg
❏15 mg ❏20 mg ❏25 mg

Directions:
❏ 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.

Qty: __________ No Refills

THALOMID®

Dosing:
❏50 mg ❏100 mg
❏150 mg ❏200 mg

Directions:
❏ Take _____ caps by mouth once daily at bedtime.

Qty: __________ No Refills

POMALYST®

Dosing:
❏1 mg ❏2 mg
❏3 mg ❏4 mg

Directions:
❏ Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle.

Qty: __________ No Refills

Female
❏ Adult Female, Not of Reproductive Potential
❏ Adult Female, Reproductive Potential
❏ Female Child, Not of Reproductive Potential
❏ Female Child, Reproductive Potential

Male
❏ Adult Male ❏ Male Child

Celgene Auth #: ______________________
Date Issued: ________________________
Confirmation #: ______________________
Date Issued: ________________________

CAPECITABINE (XELODA)

Dosing:
❏150 mg ❏500 mg
❏Take ___tabs by mouth two times a day on days 1-14 of 21 day cycle. Repeat.
❏Conjunction with radiation: Start Date:_______ for _________# of days a week.
❏Other ________________________________

Qty: __________ Refills: ___________

TEMOZOLOMIDE (TEMODAR)

Dosing:
❏_______ mg
❏Take ______mg by mouth daily for ______days with ______ days off
❏Conjunction with radiation: Start Date:_______ for _________# of days a week.
❏Other ________________________________

Qty: __________ Refills: ___________

IMATINIB (GLEEVEC)

Dosing:
❏100 mg ❏400 mg
❏Take ___tabs by mouth once a day
❏Other ___________________________

Qty: __________ Refills: ___________

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

❏ OTHER

STRENGTH:

SIG/DIRECTIONS

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

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

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact/Faxed By:		Email:	
NPI#:	TAX ID#:	Ship To: ❏ Patient ❏ MD Office 1st Order Only ❏ MD Office 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.

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
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