

# PEDIATRIC ONCOLOGY REFERRAL FORM

## PATIENT INFORMATION

Patient Name:		SSN:		DOB:	
Address:		City:		State:	Zip:
Home Phone:		Cell Phone:			
Email Address:		Parent or Guardians Name:			
Height:	Weight:	Gender:	Male	Female	
Diagnosis Code:					

## INSURANCE INFORMATION (or attach copy of cards)

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

## PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

### MEDICATION:

- Afinitor®** (everolimus)\*
- Afinitor Disperz®** (tablets for oral suspension)
- Exjade®** (deferasirox)\*
- Gleevec®** (imatinib)\*
- Jadenu®** (deferasirox)\*
- Sprycel®** (dasatinib)
- Other:** \_\_\_\_\_

\*AVAILABLE IN GENERIC

### STRENGTH:

### DIRECTIONS:

### REFILLS:

### QUANTITY:

### START OF THERAPY DATE:

**SHIP TO:**  Patient  MD Office

As required by your state, Prescriber to check "Dispense as written" or handwritten "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, and Route 300 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 copy and financial assistance on behalf of your patients.

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 BioPlus Specialty Pharmacy 13925 Yale Ave, Suite 145, Irvine, CA 92620  
 MedScripts Medical Pharmacy 1325 Miller Rd., Suite K, Greenville, SC 29607  
 River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240  
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