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	

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 Start 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)*
FARYDAK® *(panobinostat)*
FASLODEX *(fulvestrant)**
FORTEO® *(teriparatide)*
GAVRETO® *(pralsetinib)*
GLEEVEC® *(imatinib)* †*
IBRANCE® *(palbociclib)*
INLYTA® *(axitinib)*
KISQALI® *(ribociclib)* †
FEMARA® *(letrozole)**
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: _____

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:	