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 (ICD-10):		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 ☐ 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)**	**COTELLIC® *(cobimetinib)***	**GAVRETO® *(pralsetinib)***	**MEKTOVI® *(binimetinib)***	**SPRYCEL® *(dasatinib)***	**VIZIMPRO® *(dacomitinib)***
AGRYLIN® *(anagrelide)**	**CYTOXAN® *(cyclophosphamide)****	**GLEEVEC® *(imatinib)*†***	**MYLOTARG™ *(gemtuzumab ozogamicin)***	**SUTENT® *(sunitinib malate)***	**VOTRIENT® *(pazopanib)***
ALECENSA® *(alectinib)*	**DAURISMO™ *(glasdegib)***	**IBRANCE® *(palbociclib)***	**NILANDRON® *(nilutamide)***	**TAFINLAR® *(dabrafenib)***	**XALKORI® *(crizotinib)†***
BESPONSA® *(inotuzumab ozogamicin)*	**ERIVEDGE™ *(vismodegib)***	**INLYTA® *(axitinib)***	**ODOMZO® (sonidegib)**	**TALZENNA® *(talazoparib)***	**XTANDI® *(enzalutamide)***
BOSULIF® *(bosutinib)†*	**ERLEADA™ *(apalutamide)***	**KISQALI® *(letrozole)****	**ONUREG ® *(azacitidine)***	**TARCEVA® *(erlotinib)****	**YONSA® *(abiraterone acetate)***
BRAFTOVI® *(encorafenib)*	**FASLODEX *(fulvestrant)****	**LORBRENA® *(lorlatinib)†***	**PIQRAY® *(alpelisib)***	**TARGRETIN® *(bexarotene)****	**ZELBORAF® *(vemurafenib)***
CABOMETYX® *(cabozantinib)*	**FEMARA® *(letrozole)****	**LENVIMA® *(lenvatinib)***	**ROZLYTREK® *(entrectinib)***	**TASIGNA® *(nilotinib)***	**ZOLINZA™ *(vorinostat)***
COMETRIQ™ *(cabozantinib)*	**FORTEO® *(teriparatide)***	**MEKINIST™ *(trametinib)***	**RYDAPT® *(midostaurin)***	**TYKERB® *(lapatinib)****	

*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	

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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
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