CITYDRUGS

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Oncology Referral Form

Ship to: Date Shipment Needed: _____ **Office** ☐ **Patient** ☐ **Other** ☐ _____

PATIENT INFORMATION

(Complete the following or send Patient's demographic sheet)

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

SS #: _____

Date of Birth: _____ Gender _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

State License #: _____ UPIN: _____

DEA #: _____ NPI #: _____

Group or Hospital: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact Person:

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

PRIMARY DIAGNOSIS:

340 - multiple sclerosis

Other - **Please Indicate ICD9_CM code:** _____ **description:** _____

MEDICAL HISTORY:

Did patient receive other medical therapies in the last 6 mos.? Yes No if yes, date: _____ Therapies: _____

Other Medical History: Cardiac Disease Diabetes

Current Medications: _____

PRESCRIPTION INFORMATION *(Please choose induction/maintenance doses if appropriate)*

- ☐ **5FU® / Adrucil® (Fluorouracil)**
- ☐ **Abraxane® (Paclitaxel)**
- ☐ **Adrucil® / Efedux® / Carac® (Fluorouracil)**
- ☐ **Afinitor® (Everolimus)**
- ☐ **Aranesp® (Darbepoetin Alfa)**
- ☐ **Avastin® (Bevacizumab)**
- ☐ **Casodex® (Bicalutamide)**
- ☐ **CeeNu® (Lomustine)**
- ☐ **Cytoxan® (Cyclophosphomide)**
- ☐ **Doxorubicin Hydrochloride®**
- ☐ **Eloxatin® (Oxaliplatin)**
- ☐ **Erbitux® (Cetuximab)**
- ☐ **Etoposide® (Etoposide)**
- ☐ **Farydak® (Panobinostat)**
- ☐ **Faslodex® (Fulvestrant)**
- ☐ **Femara (Letrozole)**
- ☐ **Gemzar® (Gemcitabine)**
- ☐ **Gleevec® (Imatinib)**
- ☐ **Herceptin® (Trastuzumab)**
- ☐ **Hycamin® (Topotecan)**
- ☐ **IDHIFA® (Enasidenib)**
- ☐ **Jevtana® (Cabazitaxel)**
- ☐ **Keytruda® (Pembrolizumab)**
- ☐ **Kisqali® (Ribociclib)**
- ☐ **Lovenox® (Enoxaparin)**
- ☐ **Lupron® (Leuprolide)**
- ☐ **Lysodren® (Mitotane)**
- ☐ **Mekinist® (Trametinib)**
- ☐ **Methotrexate®**
- ☐ **Neulasta® (Pegfilgrastim)**
- ☐ **Neupogen® (Filgristim)**
- ☐ **Ninlaro® (Ixazomib)**
- ☐ **Nilandron® (Nilutamide)**
- ☐ **Paraplat® (Carboplatin)**
- ☐ **Procrit® (Epoetin Alfa)**
- ☐ **Promacta® (Eltrombopaq Olamine)**
- ☐ **Provenge® (Sipuleucel-t)**
- ☐ **Rituxan® (Rituximab)**
- ☐ **Rydapt® (Midostaurin)**
- ☐ **Sprycel® (Dasatinib)**
- ☐ **Syndros™ (Orexigenic)**
- ☐ **Tafinlar® (Dabrafenib)**
- ☐ **Tarceva® (Erlotinib Hydrochloride)**
- ☐ **Tasigna® (Nilotinib)**
- ☐ **Taxol® (Paclitaxel)**
- ☐ **Taxotere® (Docetaxel)**
- ☐ **Temodar® (Temozolomide)**
- ☐ **Torisel® (Temsirolimus)**
- ☐ **Treanda® (Bendamustine HCL)**
- ☐ **Trelstar® (Triptorelin Pamoate)**
- ☐ **Tykerb® (Lapatinib)**
- ☐ **Velcade® (Bortezomib)**
- ☐ **Votrient® (Pazopanib)**
- ☐ **Xeloda® (Capecitabine)**
- ☐ **Xgeva® (Denosumab)**
- ☐ **Yervoy® (Ipilimumab)**
- ☐ **Zaltrap® (Ziv-aflibercept)**
- ☐ **Zarxio® (Filgrastim-sndz)**
- ☐ **Zelboraf® (Vemurafenib)**
- ☐ **Zolinza® (Vorinostat)**
- ☐ **Zydelig® (Idelalisib)**
- ☐ **Zykadia® (Ceritinib)**
- ☐ **Zytiga® (Abiraterone Acetate)**
- ☐ **Other** _____

STRENGTH	SIG./DIRECTIONS
Refills:	**Quantity:**

Any known allergies? Yes No List: _____

By signing this form Physician authorized CityDrugs Pharmacy to act as his or her agent in the initiation and execution of patient's insurance Prior Authorization process and agrees to provide CityDrugs Pharmacy all lab results to assist with identification of treatment duration and or futility. The Physician understands that since the patient is on continuous therapy and will inform the Pharmacy should the therapy be discontinued.

Physician's Signature: _____ ☐ DAW (Dispense as Written) **Date** ____/____/____