IV ONCOLOGY PRESCRIPTION REFFERAL FORM

410 Cloverleaf Drive, Baldwin Park, CA 91706 Ph: 800-540-4700
Fax: 800-540-3400

Patient

Patient Name: ______________________ DOB: __________
Address: ______________________ SS#: ____-____-____
City: __________ State: ________ Zip: ______
Phone: __________ Alt Phone: __________

Allergies: __________
Sex: O Male O Female
Height: __________
Weight: __________

Prescriber

Practice Name: ______________________
Address: ______________________
City: __________ State: __________ Zip: __________
Phone: __________ Fax: __________
Office Contact: __________ Phone: __________
email: ______________________

Prescriber	NPI
O	DEA
Prescriber	NPI
O	DEA

Clinical

Primary Diagnosis: __________
ICD9: __________

Secondary Diagnosis: __________
ICD9: __________

Chemo Regimen: ______________________
____

Chemo Cycle: ______________________
*please provide most recent chart notes & labs

Prescription

❑ Abraxane	❑ Cytoxan	❑ Faslodex	❑ Navelbine	❑ Zoladex
❑ Adriamycin	❑ Dacarbazine	❑ Fludarabine	❑ Novantrone	❑ Neupogen
❑ Aredia	❑ Dactinomycin	❑ Fluorouracil	❑ Remicade	❑ Neulasta
❑ Avastin	❑ Daunorubicin	❑ Gemzar	❑ Rituxan	❑ Procrit
❑ BiCNU	❑ Doxil	❑ Herceptin	❑ Taxol	❑ Epogen
❑ Bleomycin	❑ Doxorubicin	❑ Hycamtin	❑ Taxotere	❑ Aranesp
❑ Campath	❑ Eloxatin	❑ Ifex	❑ Thiotepa	❑ Neumega
❑ Camptosar	❑ Ellence	❑ Lupron	❑ Velcade	❑ __________
❑ Carboplatin	❑ Erbitux	❑ Mesna	❑ Vinblastine	❑ __________
❑ Cisplatin	❑ Ethyol	❑ MTX	❑ Vincristine	
❑ Cytarabine	❑ Etoposide	❑ Mitomycin	❑ Zanosar	

Date Medication Needed: __________
Ship to: O Patient's Home
O Prescriber's Office

Directions: __________
Quantity: __________ Refills: __________

Prior Authorization

O *I authorize Premier Pharmacy and it's representatives to act as an agent to initiate & execute prior authorization for above patient*
In order to expedite the prior authorization process, please provide chart notes, most recent labs and chemotherapy info

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

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