PREMIER PHARMACY SERVICES

Yoomi So: 626.626.9436 • Alma Chavez: 626.626.9428

24/7 After-Hours Svc:
Phone: 800.540.4700
Fax: 855.292.2590

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

ORAL ONCOLOGY RX REFERRAL FORM

Ship to: ☐ **Patient's Home** ☐ **Prescriber's Office**

Date of Medication Needed: _____

Patient Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Allergies: _____

Sex: ◯ Male ◯ Female

Height: _____

Weight: _____

Clinical

Primary Diagnosis: _____

ICD10 _____

Secondary Diagnosis _____

ICD10 _____

Chemo Regimen: _____

_____

Chemo Cycle: _____

* Please provide most recent chart notes & labs

Prescription

Drug: _____

Directions: _____

_____

Quantity: _____ Refills: _____

Drug: _____

Directions: _____

_____

Quantity: _____ Refills: _____

☐ Afinitor	☐ Rydapt
☐ Cerezyme	☐ Sprycel
☐ Erivedge	☐ Tafinlar
☐ Femara	☐ Tarceva
☐ Gleevec	☐ Tasigna
☐ Hycamtim	☐ Temodar
☐ Jadenu	☐ Tykerb
☐ Kisqali	☐ Votrient
☐ Kytril	☐ Xeloda
☐ Lupron	☐ Zelboraf
☐ Mekinist	☐ Zykadia
☐ Mozobil	☐ Zytiga
☐ Promacta	☐ Other

Prescriber Information

Physician Name (please print): _____ Contact Name: _____

NPI #: _____ DEA#: _____ Tax ID #: _____

Office Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____ Email: _____

I authorize Premier Pharmacy and it's representatives to act as an agent to initiate and execute prior authorization for above patient. To expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ DAW (dispense as written) Date: _____/_____/_____

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