PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

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

INJECTABLE ONCOLOGY
REFERRAL FORM

Ship to: ☐ Patient ☐ Physician ☐ Other: _____

Patient Information

Patient Last Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Email: _____ Alternate Contact Info: _____

Gender: ☐ Male ☐ Female Allergies: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Diagnosis Information for Prior Authorization and Funding Support

Primary Diagnosis: _____

DX Date (needed for funding): _____ ICD-10 Code: _____

Secondary Diagnosis: _____

DX Date (needed for funding): _____ ICD-10 Code: _____

Prescription Information

Injectable Oncology Medication

☐ Abraxane®	☐ Cisplatin	☐ Ellence®	☐ Gemzar®	☐ Navelbine®	☐ Velcade®
☐ Adriamycin®	☐ Cytarabine	☐ Erbitux®	☐ Herceptin®	☐ Novantron®	☐ Vinblastine
☐ Avastin®	☐ Cytoxan®	☐ Ethyol®	☐ Hycamtin®	☐ Remicade®	☐ Vincristine
☐ BiCNU®	☐ Darcarbazine	☐ Etoposide	☐ Ifex®	☐ Rituxan®	☐ Zanosar®
☐ Bleomycin	☐ Dactinomycin	☐ Faslodex®	☐ Lupron®	☐ Taxol®	☐ Zoladex®
☐ Campath®	☐ Daunorubicin	☐ Fludarabine	☐ MTX	☐ Taxotere®	
☐ Camptosar®	☐ Doxil®	☐ Fluorouracil	☐ Mitomycin	☐ Thiotepa	☐ Other: _____
☐ Carboplatin	☐ Eloxatin®				

Injectable Oncology Medication Directions:	Dispense	Refills
Dose/Strength: _____ Directions: _____ Infusion Cycle: _____ Date of infusion: _____	_____	_____

Additional / Supportive Medications

☐ Aredia®	☐ Neupogen®	☐ Procrit®	☐ Aranesp®	
☐ Mesna	☐ Neulasta®	☐ Epogen®	☐ Neumega®	☐ Other: _____

Additional / Supportive Medications Additional / Supportive Medications Directions	Dispense	Refills
	_____	_____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

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

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

IMPORTANT NOTICE: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.