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

ORAL ONCOLOGY
REFERRAL FORM

Ship to: ☐ Patient ☐ Physician ☐ Other: _____

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Alternate Contact Name: _____ Alt Contact Phone: _____

Gender: ☐ Male ☐ Female Allergies: _____ E-Mail: _____

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

Oral Oncology Medication

☐ Abiraterone Acetate	☐ Erivedge®	☐ Imatinib Mesylate	☐ Sprycel®	☐ Temozolomide
☐ Afinitor®	☐ Erlotinib	☐ Kisqali®	☐ Talfinlar®	☐ Tykerb®
☐ Aromasin®	☐ Everolimus	☐ Lapatinib	☐ Tarceva®	☐ Votrient®
☐ Bexarotene	☐ Farydak®	☐ Mekinist®	☐ Targretin®	☐ Xeloda®
☐ Capecitabine	☐ Gleevec®	☐ Ninlaro®	☐ Tasigna®	☐ Xtandi®
☐ Deferasirox	☐ Hycamtin®	☐ Rydapt®	☐ Temodar®	☐ Zytiga®

Oral Oncology Medication Directions:	Quantity	Refills
Cycle Days: _____ days on, _____ days off	# _____ ☐ Tablet ☐ Capsule	_____

Additional / Supportive Medications

☐ Akynzeo®	☐ Dexamethasone	☐ Granix®	☐ Procrit®	☐ Zofran®
☐ Anzemet®	☐ Emend®	☐ Jadenu™	☐ Promacta®	☐ _____
☐ Aranesp®	☐ Epogen®	☐ Neupogen®	☐ Tavalisse®	
☐ Arixtra®	☐ Exjade™	☐ Prednisone	☐ Zarxio®	

Additional / Supportive Medications Additional / Supportive Medications Directions	Quantity	Refills
	# _____ ☐ Tablet ☐ Capsule	_____

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:** _____/_____/_____