



MORRISTOWN PHARMACY

ONCOLOGY PRESCRIPTION REFERRAL FORM

95 Madison Ave #110 | Morristown, NJ, 07960

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Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

NEW PATIENT CURRENT PATIENT

Last updated: May 2017

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-10 Diagnosis Code _____ Allergies _____ BSA _____ m²
 Biopsy Yes No Results _____ Patient currently on therapy Yes No Date of next blood work _____

INSURANCE INFORMATION Please fax copy of insurance card (front & back)

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

- | | | |
|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> Afinitor | <input type="checkbox"/> Glivec | <input type="checkbox"/> Tasigna |
| <input type="checkbox"/> Avastin | <input type="checkbox"/> Herceptin | <input type="checkbox"/> Temodar |
| <input type="checkbox"/> Aromasin | <input type="checkbox"/> Kadcyca | <input type="checkbox"/> Velcade |
| <input type="checkbox"/> Docetaxel | <input type="checkbox"/> Opdivo | <input type="checkbox"/> Xeloda |
| <input type="checkbox"/> Erbitux | <input type="checkbox"/> Rituxan | <input type="checkbox"/> Yervoy |
| <input type="checkbox"/> Eloxatin | <input type="checkbox"/> Sivextro | <input type="checkbox"/> Zolanza |
| <input type="checkbox"/> Etoposide | <input type="checkbox"/> Sprycel | <input type="checkbox"/> Zometa |
| <input type="checkbox"/> Gleevec (Imatinib) | <input type="checkbox"/> Sylatron | <input type="checkbox"/> _____ |

Strength _____

SIG _____

QTY _____ Refills _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

XGEVA Strength: 120 mg/1.7 mL (70 mg/mL) single-use vial QTY _____ Refills _____
 120 mg SQ every 4 weeks in the upper arm, upper thigh, or abdomen
 120 mg SQ every 4 weeks in the upper arm, upper thigh, or abdomen
 Additional 120 mg doses on days 8 and 15 of the first month of therapy

Antiemetics Chemo-induced
 Compazine Emend Zofran Sancuso Transdermal Patch Other
 Dosage _____ QTY _____ Refills _____

Neupogen
 300 mcg SQ 480 mcg SQ Other _____ QTY _____ Refills _____
 Daily x _____ days Every week BIW TIW

Procrit 40,000 units SQ Weekly Other _____ QTY _____ Refills _____

Aranesp **Caphosol** _____

Neumega 5mg vial **Zofran** _____

Arixtra _____ _____

Dosage _____ Sig _____ QTY _____ Refills _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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