

# Oncology Referral Form

Please fax to:

866.279.3315

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work/Mobile Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female  
Primary Caregiver \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Please send a copy of the patient's insurance card, both front and back.)

1. Primary Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Employer \_\_\_\_\_ Relationship \_\_\_\_\_  
2. Secondary Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone \_\_\_\_\_  
Insured's Name \_\_\_\_\_ Insured's Employer \_\_\_\_\_ Relationship \_\_\_\_\_

## CLINICAL INFORMATION

\*\*\*\*\* Please send all Clinical Notes, Test and Lab Results to Help Facilitate Prior Authorization Processing \*\*\*\*\*

ICD-10 Code \_\_\_\_\_ Primary Diagnosis \_\_\_\_\_ Current Weight \_\_\_\_\_ kg/lb Height \_\_\_\_\_ inches/cm BSA \_\_\_\_\_ m2  
Allergies:  Yes  No If yes, please list \_\_\_\_\_  
Therapy:  New  Restart Prior Therapies: \_\_\_\_\_

## MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

## SUPPORTIVE MEDICATION

Drug Name	Dose/Strength	Directions	Quantity	Refills

Deliver To:  Home  Physician\* *\*If shipped to physician's office, physician accepts on behalf of patient for administration in office.*

## PHYSICIAN INFORMATION

Physician Name \_\_\_\_\_ Contact Name \_\_\_\_\_  
NPI # \_\_\_\_\_ DEA # \_\_\_\_\_ Lic # \_\_\_\_\_ Tax ID# \_\_\_\_\_  
Phone/Fax \_\_\_\_\_ E-mail \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer. I also certify that all the information above is correct to the best of my knowledge and the prescribed therapy is a medical necessity.

Physician Signature \_\_\_\_\_ Dispense as Written \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

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