aleracare
advanced specialty pharmacy

Chemotherapy Induced Nausea and Vomiting

Referral Form

Patient Information			Prescriber Information	
Patient Name:		DOB:	Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height:	Weight:	Allergies:	Phone:	Fax:
Emergency Contant:		Phone:	Contact Person:	

Client Considerations

Prescriber's Name:

- R11.0 Nausea
- R11.11 Vomiting without Nausea
- R11.2 Nausea with vomiting unspecified
- Other (please specify): ____

Medication	Dose	Directions for Use	Qty	Refills
SANCUSO® (Granisteron Transdermal Patch)	34.3mg	Apply single transdermal patch to the upper outer arm minimally 24 hours before chemotherapy. Remove patch minimally 24 hours after completion of chemotherapy.		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature ______________________ **Date** ______________________