aleracare
advanced specialty pharmacy

Oncology
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 Consideration

Diagnosis (ICD 10): _____

Oral Drugs

◯ AFINITOR®	◯ MEKINIST®	◯ TASIGNA®
◯ ARIMIDEX®	◯ NINLARO®	◯ TEMODAR®
◯ AROMASIN®	◯ NOXAFIL®	◯ TYKERB®
◯ FARYDAK®	◯ ODOMZO®	◯ VOTRIENT®
◯ FEMARA®	◯ RYDAPT®	◯ XELODA®
◯ GLEEVEC®	◯ SPRYCEL®	◯ ZOLINZA®
◯ HYCAMTIN®	◯ TAFINLAR®	◯ ZYKADIA®
◯ JADENU®	◯ TAMOXIFEN®	◯ ZYTIGA®
◯ KISQALI®		

◯ OTHER: _____

Prescribing Information

◯ Strength: _____
◯ Quantity: _____
◯ Refills: _____
◯ SIG: _____

Injectable Drugs

◯ ARANESP®	◯ LOVENOX®	◯ PERJETA®
◯ ARIXTRA®	◯ LUPRON®	◯ PROCRIT®
◯ FOLOTYN®	◯ NEULASTA®	◯ SANDOSTATIN®
◯ FRAGMIN®	◯ NEUPOGEN®	◯ SYLATRON®
◯ LEUKINE®	◯ PEGASYS®	

◯ OTHER: _____

Prescribing Information

◯ Strength: _____
◯ Quantity: _____
◯ Refills: _____
◯ SIG: _____

IV Infusion Drugs

◯ ALIMTA®	◯ ERBITUX®	◯ KADCYLA®	◯ TAXOTERE®
◯ AVASTIN®	◯ EMPLICITI®	◯ HERCEPTIN	◯ RITUXAN®
◯ DARZALEX®	◯ GAZYVA®	◯ RECLAST®	◯ 5 FU
◯ CYCLOPHOSPHAMIDE		◯ DOXORUBICIN	

◯ OTHER: _____

Prescribing Information

◯ Strength: _____
◯ Quantity: _____
◯ Refills: _____
◯ SIG: _____

Supportive Drugs

◯ EMEND®	◯ NS FLUSH	◯ SANCUSO®
◯ HEPARIN FLUSH	◯ PROMACTA®	◯ ZOFRAN®

◯ OTHER: _____

Prescribing Information

◯ Strength: _____
◯ Quantity: _____
◯ Refills: _____
◯ SIG: _____

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** _____