alera care
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:	

Is the patient pregnant, planning a pregnancy or nursing: Yes No

Does the patient need interpreter services: Yes No

Documentation (Required)

Insurance Card (front and back) Current Medications History/Progress Notes

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**