

# Oncology Referral Form



Phone: 808-533-8887  
 Fax: 808-533-1888  
 E-Prescribing Available

Attention: \_\_\_\_\_ Need By Date: \_\_\_\_\_ First Ship To:  Patient  Physician

<b>Patient</b>	Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Address: _____ City: _____ State: _____ Zip: _____
	Home#: _____ Work #: _____ Cell#: _____ Best time to call: <input type="checkbox"/> AM <input type="checkbox"/> PM
	Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____
	Allergies: _____ <input type="checkbox"/> NKDA

<b>Provider</b>	Physician Name: _____ Practice Name: _____ State Lic#: _____ DEA#: _____
	Address: _____ City: _____ State: _____ Zip: _____ NPI#: _____
	Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

<b>Insurance</b>	Primary Insurance: _____ ID: _____ Phone: _____
	Secondary Insurance: _____ ID: _____ Phone: _____
	* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

<b>Clinical Info</b>	Diagnosis: _____ (ICD-10): _____ Naïve to Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No
	ER+: <input type="checkbox"/> Yes <input type="checkbox"/> No      HER2: <input type="checkbox"/> Positive <input type="checkbox"/> Negative      Metastatic: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Serum Creatinine: ____ (____/____/____)      HgB: ____ (____/____/____)      HCT: ____ (____/____/____)
	Renal Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No      Liver Dysfunction: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<i>To expedite prior authorization services, please attach Chemo regimen/schedule, last clinical notes and labs</i>

## Prescription

**Oral Oncolytics**      Weight: \_\_\_\_\_ (KG)      Height: \_\_\_\_\_ (CM)      BSA: \_\_\_\_\_ (M<sup>2</sup>)

<input type="checkbox"/> Afinitor <sup>®</sup> <input type="checkbox"/> Afinitor <sup>®</sup> Disperz <input type="checkbox"/> Exjade <sup>®</sup> <input type="checkbox"/> Gleevec <sup>®</sup> <input type="checkbox"/> Hycamtin <sup>®</sup> <input type="checkbox"/> Jadenu <sup>®</sup> <input type="checkbox"/> Mekinist <sup>®</sup>	<input type="checkbox"/> Nexavar <sup>®</sup> <input type="checkbox"/> Promacta <sup>®</sup> <input type="checkbox"/> Sprycel <sup>®</sup> <input type="checkbox"/> Stivarga <sup>®</sup> <input type="checkbox"/> Tafinlar <sup>®</sup> <input type="checkbox"/> Targretin <sup>®</sup> <input type="checkbox"/> Tasigna <sup>®</sup>	<input type="checkbox"/> Temodar <sup>®</sup> <input type="checkbox"/> Tykerb <sup>®</sup> <input type="checkbox"/> Vidaza <sup>®</sup> <input type="checkbox"/> Votrient <sup>®</sup> <input type="checkbox"/> Xeloda <sup>®</sup> <input type="checkbox"/> Zolinza <sup>®</sup> <input type="checkbox"/> Zydelig <sup>™</sup>	<input type="checkbox"/> Zykadia <sup>™</sup>
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Strength: \_\_\_\_\_ Quantity: \_\_\_\_\_ Directions: \_\_\_\_\_  
 Refill #: \_\_\_\_\_

**Antiemetics:**     Zofran | ODT     Sancuso  
 Dose: \_\_\_\_\_ SIG: \_\_\_\_\_ QTY: \_\_\_\_\_ Refills: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 I authorize The Honolulu Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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