Oncology Referral Form

THE HONOLULU PHARMACY
COMPOUNDING PHARMACY & SPECIALTY PHARMACY

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

Attention: _____ Need By Date: _____ First Ship To: ☐ Patient ☐ Physician

Patient

Patient Name:_____ DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Work #: _____ Cell#: _____ Best time to call: ☐ AM ☐ PM

Soc. Sec #: _____ Ethnicity: _____ Primary Language: _____

Allergies: _____ ☐ NKDA

Provider

Physician Name:_____ Practice Name:_____ State Lic#: _____ DEA#: _____

Address:_____ City:_____ State:_____ Zip:_____ NPI#: _____

Phone#: _____ Fax#: _____ Nurse/Key Office Contact: _____ Ext.: _____

Insurance

Primary Insurance: _____ ID: _____ Phone: _____

Secondary Insurance: _____ ID: _____ Phone: _____

* Please provide a copy of the insurance card (front and back) and MEDICATION LIST

Clinical Info

Diagnosis: _____ (ICD-10): _____ Naïve to Treatment: ☐ Yes ☐ No

ER+: ☐ Yes ☐ No HER2: ☐ Positive ☐ Negative Metastatic: ☐ Yes ☐ No

Serum Creatinine: _____(_____/_____/_____) HgB: _____(_____/_____/_____) HCT: _____(_____/_____/_____)

Renal Dysfunction: ☐ Yes ☐ No Liver Dysfunction: ☐ Yes ☐ No

To expedite prior authorization services, please attach Chemo regimen/schedule, last clinical notes and labs

Prescription

Oral Oncolytics Weight: _____ (KG) Height: _____ (CM) BSA: _____ (M^2)

☐ Afinitor®	☐ Nexavar®	☐ Temodar®	☐ Zykadia™
☐ Afinitor® Disperz	☐ Promacta®	☐ Tykerb®	
☐ Exjade®	☐ Sprycel®	☐ Vidaza®	
☐ Gleevec®	☐ Stivarga®	☐ Votrient®	
☐ Hycamtin®	☐ Tafinlar®	☐ Xeloda®	
☐ Jadenu®	☐ Targretin®	☐ Zolinza®	
☐ Mekinist®	☐ Tasigna®	☐ Zydelig™	

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.