US Bioservices
AmerisourceBergen

IV Oncology Referral Form

Phone: (877) 757-0667
Fax: (888) 899-0067

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:________

1. Patient Information

Last Name: ________ Home Phone: ________ Work/Mobile Phone: ________
First Name: ________ Home Address: ________
S.S. #: ________ Date of Birth: ________ City: ________ State: ________ Zip: ________
Guardian/Caregiver: ________ Sex: ☐ Male ☐ Female Height: ________ Weight: ________ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: ________ Phone: ________ Prescription Card: ________ Phone: ________
Subscriber Name: ________ Policy #: ________ BIN/PCN: ________
Policy #: ________ Group #: ________ Medicare #: ________ Medicaid #: ________

3. Prescriber Information

Prescriber Name: ________ ☐ MD ☐ DO ☐ NP ☐ PA License #: ________ NPI #: ________ DEA #: ________
Practice Name: ________ Phone: ________ Fax: ________
Address: ________ Office Contact: ________ Phone: ________
City: ________ State: ________ Zip: ________ Collaborating Physician: ________

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: ________ Meds Tried & Failed: ________
Secondary ICD-10: ________
Allergies: ________ Concurrent Medications: ________
Vaccination History: ________

5. Prescription Information

MEDICATION	DOSE/STRENGTH	SIG	INF. CYCLE	QUANTITY	REFILLS	DATE OF INF.
☐ ABRAXANE®						
☐ ADCENTRIS®						
☐ ALIMTA®						
☐ AVASTIN®						
☐ CARBOPLATIN						
☐ DOCETAXEL						
☐ ELOXATIN®						
☐ ERBITUX®						
☐ GEMCITABINE						
☐ HERCEPTIN®						
☐ KADCLYA®						
☐ KEYTRUDA®						
☐ ONIVYDE®						
☐ OPDIVO®						
☐ PACLITAXEL						
☐ RITUXAN®						
☐ SYNRIBO®						
☐ VELCADE®						
☐ YERVOY®						
☐ ZOMETA®						

SUPPORTIVE MEDICATIONS	DOSE/STRENGTH	SIG	INF. CYCLE	QTY	REFILLS	DATE OF INF.
☐ ARANESP® ☐ NEULASTA® ☐ PROCRIT® ☐ EPOGEN® ☐ NEUPOGEN®						

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature ________ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____