US Bioservices
AmerisourceBergen

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

☐ AFINITOR®	☐ COTELLIC™	☐ IBRANCE®	☐ MEKINIST®	☐ SPRYCEL®	☐ TASIGNA®	☐ XELODA®
☐ ALECENSA®	☐ DAURISMO™	☐ INLYTA®	☐ MEKTOVI®	☐ STIVARGA®	☐ TEMODAR®	☐ XTANDI®
☐ BALVERSA™	☐ ERIVEDGE®	☐ INTRON® A	☐ NEXAVAR®	☐ SUTENT®	☐ TYKERB®	☐ ZEJULA™
☐ BOSULIF®	☐ ERLEADA™	☐ IRESSA®	☐ NINLARO®	☐ TAFINLAR®	☐ VERZENIO™	☐ ZELBORAF®
☐ BRAFTOVI™	☐ FARYDAK®	☐ JAKAFI®	☐ ODOMZO®	☐ TAGRISSO®	☐ VITRAKVI®	☐ ZYKADIA®
☐ CABOMETYX®	☐ FEMARA®	☐ KISQALI®	☐ RUBRACA™	☐ TALZENNA™	☐ VOTRIENT®	☐ ZYTIGA®
☐ COPIKTRA™	☐ GLEEVEC®	☐ LUPRON®	☐ RYDAPT®	☐ TARCEVA®	☐ XALKORI®	☐ _____

Dose:_____ Qty:_____ Refills:_____
Sig:_____
Cycle Days:_____days on, _____days off

KISQALI® *dispensed with:* ☐ ARIMIDEX® ☐ AROMASIN® ☐ FEMARA®

IBRANCE® *dispensed with:* ☐ XELODA® ☐ FEMARA®

TYKERB® *dispensed with:* ☐ FEMARA® ☐ FASLODEX®

COTELLIC® *dispensed with:* ☐ ZELBORAF®

VERZENIO® *dispensed with:* ☐ FASLODEX®

BRAFTOVI™ *dispensed with:* ☐ MEKTOVI®

Dosage:_____ Qty:_____ Refills:_____
Sig:_____
Cycle Days:_____days on, _____days off

☐ **REVLIMID®** ☐ **THALOMID®** ☐ **POMALYST®**

☐ Adult Female - NOT of Reproductive Potential ☐ Adult Female - Reproductive Potential ☐ Adult Male

☐ Female Child - NOT of Reproductive Potential ☐ Female Child - Reproductive Potential ☐ Male Child

Dosage:_____ Qty:_____ Refills:_____
Sig:_____
Cycle Days:_____days on, _____days off
Authorization #_____

ADDITIONAL MEDICATIONS

☐ AKYNZEO®	☐ ARIXTRA®	☐ EPOGEN®	☐ JADENU™	☐ PROCRIT®	☐ ZARXIO®
☐ ANZEMET®	☐ DEXAMETHASONE	☐ EXJADE™	☐ NEUPOGEN®	☐ PROMACTA®	☐ ZOFRAN®
☐ ARANESP®	☐ EMEND®	☐ GRANIX®	☐ PREDNISONE	☐ TAVALISSE™	☐ _____

Dosage:_____ Qty:_____ Refills:_____
Sig:_____
Cycle Days:_____days on, _____days off

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 to act on behalf of myself and my patient to initiate any de minimus authorization process from health plans 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 _____ / _____ / _____