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: ________ ☐ lb ☐ kg

## 2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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® | ☐ ERIVEDGE® | ☐ JAKAFI® | ☐ ORGOVYX™ | ☐ TABRECTA™ | ☐ VITRAKVI® | ☐ ZYKADIA® |
| ☐ ALECENSA® | ☐ ERLEADA® | ☐ KISQALI® | ☐ PIQRAY® | ☐ TAFINLAR® | ☐ VOTRIENT® | ☐ ZYTIGA® |
| ☐ BALVERSA® | ☐ FARYDAK® | ☐ LUPRON® | ☐ QINLOCK™ | ☐ TAGRISSO® | ☐ XALKORI® | |
| ☐ BOSULIF® | ☐ FEMARA® | ☐ MEKINIST® | ☐ RETEVMO™ | ☐ TALZENNA® | ☐ XELODA® | |
| ☐ BRAFTOVI® | ☐ GLEEVEC® | ☐ MEKTOVI® | ☐ ROZLYTREK® | ☐ TARCEVA® | ☐ XOSPATA® | |
| ☐ CABOMETYX® | ☐ IBRANCE® | ☐ NEXAVAR® | ☐ RYDAPT® | ☐ TASIGNA® | ☐ XPOVIO® | |
| ☐ COPIKTRA® | ☐ INLYTA® | ☐ NINLARO® | ☐ SPRYCEL® | ☐ TEMODAR® | ☐ XTANDI® | |
| ☐ COTELLIC® | ☐ INREBIC® | ☐ NUBEQA® | ☐ STIVARGA® | ☐ TYKERB® | ☐ ZEJULA® | |
| ☐ DAURISMO™ | ☐ IRESSA® | ☐ ODOMZO® | ☐ SUTENT® | ☐ VERZENIO® | ☐ ZELBORAF® | |

Dosage: ________ 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® | ☐ EMEND® | ☐ NEUPOGEN® | ☐ PROMACTA® | ☐ VARUBI® | ☐ ________ |
| ☐ ANZEMET® | ☐ EPOGEN® | ☐ NIVESTYM® | ☐ RETACRIT® | ☐ ZARXIO® | |
| ☐ ARANESP® | ☐ FULPHILA® | ☐ PREDNISONE | ☐ TAVALISSE® | ☐ ZIEXTENZO® | |
| ☐ DEXAMETHASONE | ☐ GRANIX® | ☐ PROCRIT® | ☐ UDENYCA® | ☐ ZOFRAN® | |

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 ____ / ____ / ____

ONC 20210208_02