

ORAL ONCOLOGY REFERRAL FORM



Phone: 1-888-315-3395

Fax: 1-888-315-3270

Attn: _____

Today's Date: _____ Shipment Needed: _____

Ship To: Patient Physician

Nurse Instruction Needed? Yes No

Agency: _____

Permission to contact pt: Yes No

* All the supplies including syringes and needles will be dispensed if needed.

Patient Information

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Soc. Sec #: _____ - _____ - _____ Date of Birth: _____
 Allergies: _____ Sex: Male Female

Doctor Information

Physician Name: _____
 State Lic #: _____ DEA #: _____
 NPI #: _____ Specialty: _____
 Practice Name/Hospital: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Nurse/Key Office Contact: _____

Insurance Information (Please submit a copy of the front and back of the insurance card if possible)

Primary Insurance: _____ Cardholder Name: _____
 Relationship: _____ I.D. #: _____ GRP # _____ Phone # _____
 Secondary Insurance: _____ Cardholder Name: _____
 Relationship: _____ I.D. #: _____ GRP # _____ Phone # _____

Statement of Medical Necessity

Diagnosis:

<input type="checkbox"/> 153.154 Metastatic Colorectal Cancer	<input type="checkbox"/> 695.2 Erythema Nodosum (ENL)	<input type="checkbox"/> 155.0 Hepatocellular Carcinoma
<input type="checkbox"/> 202.1 Cutaneous T-Cell Lymphoma (Mycosis Fungoides)	<input type="checkbox"/> 205.1 Chronic Myeloid Leukemia	<input type="checkbox"/> 189 Renal Cell Carcinoma
<input type="checkbox"/> 162.9 Pulmonary Malignancy	<input type="checkbox"/> 203 Multiple Myeloma	<input type="checkbox"/> 152.9 Gastrointestinal Stromal Tumors
<input type="checkbox"/> 202.2 Cutaneous T-Cell Lymphoma (Sezary's Disease)	<input type="checkbox"/> 157.9 Adenocarcinoma of Pancreas	<input type="checkbox"/> 191.9 Glioblastoma
	<input type="checkbox"/> Other: _____	

Oral Chemotherapeutic Agents	Cycle repeats every _____ week(s)	Blood Modifying Agents
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<input type="checkbox"/> AFINITOR®	<input type="checkbox"/> TARCEVA	<input type="checkbox"/> NEXAVAR
<input type="checkbox"/> SPRYCEL	<input type="checkbox"/> TASIGNA	<input type="checkbox"/> ZOLINZA
<input type="checkbox"/> CYTOXAN	<input type="checkbox"/> GLEEVEC	<input type="checkbox"/> SUTENT
<input type="checkbox"/> XELODA®	<input type="checkbox"/> TEMODAR	<input type="checkbox"/> VOTRIENT
<input type="checkbox"/> VIDAZA	<input type="checkbox"/> MATULANE	<input type="checkbox"/> _____

Sig: _____
 Qty: _____ Ref: _____

<input type="checkbox"/> NEULASTA	<input type="checkbox"/> NEUPOGEN	<input type="checkbox"/> NEUMEGA
<input type="checkbox"/> PROCRIT	<input type="checkbox"/> EPOGEN	<input type="checkbox"/> ARANESP

Sig: _____
 Qty: _____ Ref: _____

THALOMID * AUTH #: _____
 REVLIMID **AUTH #: _____

Risk Category (check off)

<input type="checkbox"/> Adult Female, NOT of Childbearing Potential	<input type="checkbox"/> Child Female, NOT of Childbearing Potential
<input type="checkbox"/> Adult Female, Childbearing Potential	<input type="checkbox"/> Child Female, Childbearing Potential
<input type="checkbox"/> Adult Male	<input type="checkbox"/> Child Male

Sig: _____ Qty: _____
 (Please fax the prescription for the maximum of 28 day supply with no refill which includes authorization #)

* THALOMID prescription and authorization # is only valid for **7 days**
 REVLIMID prescription and authorization # is only valid for **14 days (7 days for FCP)

PHARMACY CONFIRMATION #: _____ **Date:** _____

Antiemetic Agents

<input type="checkbox"/> ZOFRAN	<input type="checkbox"/> ZOFRAN ODT	<input type="checkbox"/> KYTRIL
<input type="checkbox"/> ANZEMET	<input type="checkbox"/> ALOXI	<input type="checkbox"/> EMEND

Sig: _____
 Qty: _____ Ref: _____

MEDICARE GUIDELINES:
 Antiemetics must be scheduled within 2 hours before chemotherapy

Oral Mucositis

Caphosol® Oral Rinse Qty: 1 mo supply
 Sig: Swish and spit _____ doses per day, beginning at onset of cancer treatment. May use up to 10 doses/day. Ref: PRN

Other: _____ Qty: _____
 Sig: _____ Ref: _____
 Other: _____ Qty: _____
 Sig: _____ Ref: _____

*If you would like brand name, please write Medically Necessary. Please note that Axiom will dispense our formulary product unless otherwise specified.

Physician Signature: _____ **Date:** _____
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