

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL
1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____
 Preferred Contact Methods _____ Phone (to primary # provided below) _____ Text (to cell # provided below) _____ Email (to email provided below) _____
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
 Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender _____ Male _____ Female _____
 Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____
 NPI Number _____ DEA Number _____ Group or Hospital _____
 Address _____ City, State, ZIP _____
 Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to _____ Patient _____ Office _____ Other _____
Diagnosis (ICD-10):
 C61 Prostate Cancer _____ Other Code _____ Description _____
Patient Clinical Information
 Allergies _____ Weight _____ lb/kg _____ Height _____ in/cm _____ BSA: _____ m2

5 PRESCRIPTION INFORMATION

MEDICATIONS:
 Revlimid REMS™ Program Physician Auth Number: _____ Date: _____ MDS D46.9
 Pomalyst REMS™ Program Physician Auth Number: _____ Date: _____ MM C90.00
 Thalomid REMS™ Program Physician Auth Number: _____ Date: _____ MCL C83.10
DIAGNOSIS:

PREGNANCY CATEGORY:

Adult Female – Reproductive Potential _____ Adult Female – NOT of Reproductive Potential _____ Adult Male _____
 Female Child – Reproductive Potential _____ Female Child – NOT of Reproductive Potential _____ Adult Male _____

MEDICATIONS:

Bosulif® (bosutinib) _____ Lumoxiti™ (moxetumomab) _____ Revlimid® (lenalidomide) _____ Thalomid® (thalidomide) _____
 Farydak® (panobinostat) _____ Ninlaro® (ixazomib) _____ Rydapt® (midostaurin) _____ Zolanza® (vorinostat) _____
 Gleevec® (imatinib mesylate) _____ Pomalyst® (pomalidomide) _____ Sprycel® (dasatinib) _____ Zydrelig® (idelalisib) _____
 Idhifa® (enasidenib) _____ Poteligeo® (moxetumomab) _____ Targretin® Capsules (bexarotene) _____
 Jakafi® (ruxolitinib) _____ Purixan® (mercaptopurine) _____ Tasigna® (nilotinib) _____ Other: _____

PRESCRIPTIONS	DRUG NAMES/STRENGTH	SIG/DIRECTIONS	QUANTITY/REFILLS
RX 1	Other		Quantity: _____ Refills: _____
RX 2	Other		Quantity: _____ Refills: _____
RX 3	Dexamethasone		Quantity: _____ Refills: _____

Patient is interested in patient support programs _____ Ancillary supplies and kits provided as needed for administration _____

STAMP SIGNATURE NOT ALLOWED
6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED _____ DATE _____ DISPENSE AS WRITTEN _____ DATE _____

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