ONCOLOGY Referral Form

● Phone: 818-390-9696 / Toll-free: 855-265-7850 ● Fax: 818-804-3492 / 818-390-9697 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:		**Contact Person:**	
Emergency Contact/ Phone #		**Delivery:** ☐ *MD Office* ☐ *Patient Home*	

Clinical Considerations
Diagnosis (ICD 10) : _____

Oral Drugs				Prescribing Information		
☐ Afinitor® ☐ Arimidex® ☐ Aromasin® ☐ Farydak® ☐ Femara® ☐ Gleevec® ☐ Hycamtin®	☐ Jadenu® ☐ Kisqali® ☐ Mekinist® ☐ Ninlaro® ☐ Noxafil® ☐ Odomzo®	☐ Rydapt® ☐ Sprycel® ☐ Tafinlar® ☐ Tamoxifen® ☐ Tasigna® ☐ Temodar®	☐ Tykerb® ☐ Votrient® ☐ Xeloda® ☐ Zolinza® ☐ Zykadia® ☐ Zytiga®	☐ **Strength:**	☐ **Quantity:**	☐ **Refills:**
☐ **Other:**				☐ **SIG:**		

Injectable Drugs				Prescribing Information		
☐ Aranesp® ☐ Arixtra® ☐ Folotyn® ☐ Fragmin®	☐ Leukine® ☐ Lovenox® ☐ Lupron® ☐ Neulasta®	☐ Neupogen® ☐ Pegasys® ☐ Perjeta® ☐ Procrit®	☐ Sandostatin® ☐ Sylatron®	☐ **Strength:**	☐ **Quantity:**	☐ **Refills:**
☐ **Other:**				☐ **SIG:**		

IV Infusion Drugs				Prescribing Information		
☐ Alimta® ☐ Avastin® ☐ Darzalex®	☐ Erbitux® ☐ Empliciti® ☐ Gazyva®	☐ Kadcyla® ☐ Herceptin ☐ Reclast®	☐ Taxotere® ☐ Rituxan® ☐ 5 FU	☐ **Strength:**	☐ **Quantity:**	☐ **Refills:**
☐ Cyclophosphamide		☐ Doxorubicin		☐ **SIG:**		
☐ **Other:**						

Supportive Drugs			Prescribing Information		
☐ Emend® ☐ Heparin Flush	☐ NS Flush ☐ Promacta®	☐ Sancuso® ☐ Zofran®	☐ **Strength:**	☐ **Quantity:**	☐ **Refills:**
☐ **Other:**			☐ **SIG:**		

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

_____

Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**