Chemotherapy Induced Nausea and Vomiting

REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

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

Clinical Consideration
Diagnosis (ICD 10) : □ R11.0 Nausea □ R11.11 Vomiting without nausea □ R11.2 Nausea with vomiting, unspecified Other (please specify)_____

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ **Sancuso®** (Granisteron Transdermal Patch)	□ 34.3 mg	□ Apply single transdermal patch to the upper outer arm minimally 24 hours before chemotherapy. □ Remove patch minimally 24 hours after completion of chemotherapy.		

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.

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