DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

ONCOLOGY
REFERRAL FORM

Fax: **866.290.2444**

Ship To: ❑ Patient ❑ Physician/Clinic Date Shipment Needed: _____ **Rx**: ❑ New ❑ Refill _____

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alt. Phone: _____

Patient SS#: _____ DOB: _____

Allergies: _____

Gender: ❑ Male ❑ Female

Diagnosis: _____ **ICD10 Code:** _____

Patient Weight: _____ Height: _____

Primary Insurance: _____

ID#: _____ Phone: _____

Secondary Insurance: _____

ID#: _____ Phone: _____

OR

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

PRESCRIPTION INFORMATION

❑ Pomalyst ❑ Revlimid ❑ Thalomid

❑ Female Child - NOT of Reproductive Potential ❑ Adult Female - NOT of Reproductive Potential
❑ Female Child - Reproductive Potential ❑ Adult Female - Reproductive Potential
❑ Male Child ❑ Adult Male

Dose: _____ Qty: _____ Directions: _____

Authorization: _____ Date: _____ Confirmation #: _____ Date: _____ *(Pharmacy Use Only)*

❑ Dexamethasone Dose: _____ Qty: _____ Directions: _____

❑ Zytiga 250mg 4 QD (on empty stomach) Qty: _____ Refill: _____

❑ WITH Prednisone 5 mg BID w/ food Qty: _____ Refill: _____

❑ **I.V.I.G**

❑ Afinitor	❑ Ibrance	❑ Stivarga	❑ Xeloda
❑ Arimidex	❑ Jadenu	❑ Tafinlar	❑ Xtandi
❑ Bosulif	❑ Jakafi	❑ Tamoxifen	❑ Zelboraf
❑ Erivedge	❑ Mekinist	❑ Tarceva	❑ Zolinza
❑ Farydak	❑ Nexavar	❑ Tasigna	❑ Zykadia
❑ Femara	❑ Odomzo	❑ Temodar	
❑ Gleevec	❑ Sprycel	❑ Tykerb	
❑ Hycamtin	❑ Sutent	❑ Votrient	

DOSE/QUANTITY/DIRECTION:

Refill #: _____

INJECTABLES		
❑ Aranesp	❑ Lovenox	❑ Perjeta
❑ Arixtra	❑ Lupron	❑ Procrit
❑ Folotyn	❑ Neulasta	❑ Sandostatin
❑ Fragmin	❑ Neupogen	❑ Sylatron
❑ Leukine	❑ Nplate	

IV INFUSION	
❑ Avastin	❑ Herceptin
❑ Erbitux	❑ Reclast
❑ Gazyva	❑ Rituxan
❑ Kadcyla	

SUPPORT DRUGS
❑ Emend
❑ Promacta
❑ Sancuso
❑ Zofran

DOSE/QUANTITY/DIRECTION:

Refill #: _____

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____

Address: _____ License#: _____

City, State, Zip: _____ DEA#: _____

Phone: _____ Fax: _____ Contact Name: _____

Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.