

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ BSA \_\_\_\_\_ Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 Male  Female City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Daytime Tel \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_  
 Ship to Patient at  Home  Work OR Patient will pick up at  Physician Office Local Pharmacy Phone \_\_\_\_\_  
 Allergies \_\_\_\_\_ Comorbidities \_\_\_\_\_  
 Current Medications (if necessary, please fax a complete list) \_\_\_\_\_

PRACTICE NAME	PRACTICE ADDRESS	CONTACT INFORMATION	LICENSE INFORMATION
_____	_____	_____	_____
_____	_____	_____	_____

REFERRAL SOURCE INFORMATION			
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____
<input type="checkbox"/>	_____ # _____	<input type="checkbox"/>	_____ # _____

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Eligible for Medicare  Yes  No If yes, Medicare# \_\_\_\_\_ Prescription Card  Yes  No If Yes, Carrier \_\_\_\_\_  
 Tel \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
 Bin# \_\_\_\_\_ Pcn# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

**Diagnosis** ICD-10: \_\_\_\_\_ Cancer Stage:  Stage 0  Stage I  Stage II  Stage III  Stage IV  Other \_\_\_\_\_  
 Has patient been treated previously for this condition?  Yes  No (If patient has been on Xeloda, please indicate dose and duration of therapy below)  
 Medications: \_\_\_\_\_  
 Is patient currently on therapy?  Yes  No Medications: \_\_\_\_\_  
 Will patient stop taking the above medication(s) before starting the new medication?  
 Yes  No If yes, what is the washout period? \_\_\_\_\_

**PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS**

**AFINITOR tablets**  2.5 mg  5 mg  7.5 mg  10 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **BOSULIF tablets**  100 mg  500 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **CAPECITABINE**  150 mg  500 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **GLEEVEC tablets**  100 mg  400 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **HYCAMTIN tablets**  0.25 mg  1 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **IBRANCE capsules**  75 mg  100 mg  125 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **IMBRUVICA capsules**  140 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **INLYTA tablets**  1 mg  5 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **MEKINIST tablets**  0.5 mg  2 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **PROMACTA tablets**  12.5 mg  25 mg  50 mg  
 75 mg  100 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **SPRYCEL tablets**  20 mg  50 mg  70 mg  80 mg  
 100 mg  140 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **KISQALI 200mg tablets**  
 Sig: Take  600 mg  400 mg  200 mg by mouth daily  
 for 21 days followed by a 7 day rest period  
 (must be administered in combination with other aromatase inhibitor)  
 Qty:  21 (200mg QD)  42 (400mg QD)  63 (600mg QD) Refills: \_\_\_\_\_  
 **SUTENT**  12.5 mg CAP  25 mg CAP  50 mg CAP  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

**TAFINLAR capsules**  50 mg  75 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **TARCEVA tablets**  25 mg  100 mg  150 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **TASIGNA capsules**  150 mg  200 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **TEMOZOLOMIDE capsules**  5 mg  20 mg  100 mg  
 140 mg  180 mg  250 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **THALOMID capsules**  50 mg  100 mg  
 150 mg  200 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **TYKERB tablets**  250 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **VOTRIENT tablets**  200 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **XTANDI capsules**  40 mg  
 Sig: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 **ZYTIGA tablets**  250 mg; 4 tablets daily (1000 mg)  
 Local Pharmacy providing Prednisone  
 Please provide Prednisone 5mg BID  
 Sig: \_\_\_\_\_ Qty: 60 Refills: \_\_\_\_\_

**SUPPORTIVE AGENTS**  **NEUPOGEN**  **ARANESP**  **NEULASTA**  
 **PROCRIT**  **EPOGEN**  **XGEVA**  
 Dosage: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_

**OTHER** \_\_\_\_\_  
 Dosage: \_\_\_\_\_ Qty: \_\_\_\_\_ Refills: \_\_\_\_\_  
 Sig: \_\_\_\_\_

 = Restricted access medication as of June 2017

By signing this form and utilizing our services, you are authorizing QuickRx Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS) \_\_\_\_\_ **Date** \_\_\_\_\_

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Provider please fax completed referral form to **QuickRx Specialty Pharmacy** at **800-540-1852** Visit **www.QuickRxSpecialty.com** for online fillable forms.



# NEW REFERRAL CHECKLIST

## PLEASE USE THIS CHECKLIST FOR PATIENTS WITH ORAL ONCOLOGY

Please use the attached checklist as a reference in order to provide the proper documentation to process the required prior authorization for your patient's treatment.

All lab reports (or EMR) must contain the following information within the last 30 days.

***Please forward any updates to us you receive from the insurance company regarding approvals or denials***

### **REQUIRED INFORMATION:**

- Patient name
- Patient Demographics (Address, Phone Number, DOB, etc...)
- Medication list and allergies
- Insurance information with RX insurance. Please include copy of card.

If the only card included is a medical card, please include local pharmacy information.

- MD name/NPI/Office contact/Phone number
- Drug indicated with refills
- MD signature and date on referral form
- Recent TB test results and date
- Previous treatment
- Symptoms
- Clinical notes



**Fax the requested documentation to (800) 540-1852**  
**Toll Free: 1-800-496-6111 Direct Phone: (347) 691-3494**



[www.QuickRxSpecialty.com](http://www.QuickRxSpecialty.com)