VERBAL ORDER FORM
ONCOLOGY

QuickRX SPECIALTY PHARMACY

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Ph 347-691-3494 | Fax 347-691-3496
NPI# 1003148321 NCPDP# 3364471
info@QuickRxSpecialty.com

Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRX Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code ☐ _____ Patient currently on therapy? ☐ Yes ☐ No Date of next blood work _____
Weight _____ BSA _____m^2 Biopsy? ☐ Yes ☐ No Results _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

AFINITOR® tablets ☐ 2mg ☐ 2.5mg ☐ 5mg ☐ 7.5mg ☐ 10mg
ARIMIDEX® tablets ☐ 1mg
AROMASIN® tablets ☐ 25mg
GLEEVEC® tablets ☐ 100mg ☐ 400mg
HYCAMTIN® tablets ☐ 0.25mg ☐ 1mg
JAKAFI® tablets ☐ 5mg ☐ 10mg ☐ 15mg ☐ 20mg ☐ 25mg
KISQALI FCT® tablets ☐ 200mg ☐ 400mg ☐ 600mg
KISQALI FEMARA® CO-PK ☐ 200mg/2.5mg ☐ 400mg/2.5mg ☐ 600mg/2.5mg
LEUKERAN® tablets ☐ 2mg
MATULANE® capsules ☐ 50mg
NEXAVAR® tablet ☐ 200mg
NINLARO® capsules ☐ 2.3mg ☐ 3mg ☐ 4mg
RYDAPT® capsules ☐ 25mg
SPRYCEL® tablets ☐ 20mg ☐ 50mg ☐ 70mg ☐ 80mg ☐ 100mg ☐ 140mg
STIVARGA® tablets ☐ 40mg
SUTENT® capsules ☐ 12.5mg ☐ 25mg ☐ 37.5mg ☐ 50mg
TAMOXIFEN® tablets ☐ 20mg
TARCEVA® tablets ☐ 25mg ☐ 100mg ☐ 150mg
TASIGNA® capsules ☐ 150mg ☐ 200mg
THALOMID® capsules ☐ 50mg ☐ 100mg ☐ 150mg ☐ 200mg
TYKERB® tablets ☐ 250mg
VOTRIENT® tablets ☐ 200mg
XELODA® tablets ☐ 150mg ☐ 500mg
XTANDI® capsules ☐ 40mg
ZOLINZA® capsules ☐ 100mg
ZYTIGA™ tablets ☐ 250mg ☐ 500mg
SIG: _____ QTY: _____ Refill: _____

ABRAXANE® Single Dose Vial ☐ 100mg
ALIMTA® Single Dose Vial ☐ 100mg ☐ 500mg
CYCLOPHOSPHAMIDE Single Dose Vial ☐ 500mg ☐ 1g ☐ 2g
Tabs ☐ 25mg ☐ 50mg
ERBITUX® Single Dose Vial ☐ 100mg/50mL ☐ 200mg/100mL
FASLODEX® Syringes ☐ 250mg/5 ml
JEVTANA® Kit ☐ 60mg/1.5ml
TARGRETIN® (bexarotene) ☐ 75mg capsules ☐ 1% Gel 60gm ☐ DAW-1
VELCADE® (bortezomib) Single Dose Vial ☐ 3.5mg ☐
SIG: _____ QTY: _____ Refill: _____

ETOPOSIDE® solution ☐ 100mg/5mL ☐ 500mg/25mL ☐ 1g/50mL | **capsules** ☐ 50mg
HERCEPTIN® ☐ 150mg vial
RITUXAN® ☐ 100mg/10mL vial ☐ 500mg/50mL vial
TEMODAR® capsules ☐ 5mg ☐ 20mg ☐ 100mg ☐ 140mg ☐ 180mg ☐ 250mg
powder ☐ 100mg
SIG: _____ QTY: _____ Refill: _____

JADENU® tablets ☐ 90mg ☐ 180mg ☐ 360mg
SIG: _____ QTY: _____ Refill: _____

DARZALEX® Single Dose Vial ☐ 100mg/5ml ☐ 400mg/20ml
EMPLICITI® Single Dose Vial ☐ 300mg ☐ 400mg
SIG: _____ QTY: _____ Refill: _____

KEYTRUDA® Single Dose Vial ☐ 100mg/4ml
OPDIVO® Single Dose Vial ☐ 40mg/4ml ☐ 100mg/10ml ☐ 240mg/24ml
SIG: _____ QTY: _____ Refill: _____

FIRMAGON® (Degarelix for injection) ☐ 120mg vial ☐ 80mg vial
☐ Start Dose: 240mg is given as two injections of 120mg each subcutaneously
☐ Maintenance Dose: Inject 80mg subcutaneously as a single injection every 28 days
QTY: _____ Refill: _____

☐ **LUPRON DEPOT®** ☐ **ELIGARD®** *in a kit with prefilled dual chamber syringe*
☐ 7.5mg ☐ 22.5mg ☐ 30mg ☐ 45mg
☐ 1 Month Administration - 1 Injection of 7.5mg intramuscular every 4 weeks
☐ 3 Month Administration - 1 Injection of 22.5mg intramuscular every 12 weeks
☐ 4 Month Administration - 1 Injection of 30mg intramuscular every 16 weeks
☐ 6 Month Administration - 1 Injection of 45mg intramuscular every 24 weeks
QTY: _____ Refill: _____
TRELSTAR® ☐ 3.75mg ☐ 11.25mg ☐ 22.5mg
☐ 1 Month Administration - 1 Injection of 3.75mg intramuscular every 4 weeks
☐ 3 Month Administration - 1 Injection of 11.25mg intramuscular every 12 weeks
☐ 6 Month Administration - 1 Injection of 22.5mg intramuscular every 24 weeks
QTY: _____ Refill: _____

NEUPOGEN® ☐ 300mcg/0.5ml PFS ☐ 480mcg/0.8ml PFS
☐ 30 ☐ 480mcg/1.6ml Vial
SIG: _____ QTY: _____ Refill: _____
NEULASTA Single Dose Vial® ☐ 6mg/0.6ml
NEULASTA ONPRO KIT PFS® ☐ 6mg/0.6ml
SIG: _____ QTY: _____ Refill: _____
☐ **PROCRIT®** Strength _____ SIG:_____ QTY: _____ Refill: _____
☐ **ARANESP®** Strength _____ SIG:_____ QTY: _____ Refill: _____

IBRANCE® ☐ SIG: QD with food for 21 days, then 7 days off QTY: 21 Refill: _____
☐ QTY: 28 Refill: _____

ZOLADEX® PFS ☐ 3.6mg/ml ☐ 10.8mg/ml
☐ SIG: Inject 3.6mg/ml PFS subcutaneously every 28 days QTY: _____ Refill: _____
☐ SIG: Inject 10.8mg/ml PFS subcutaneously every 12 weeks QTY: _____ Refill: _____

OTHER MEDICATION_____
SIG:_____ **QTY:**_____ **REFILL:**_____

PFSP is able to fill supplemental therapy for your patients, including but not limited to antiemetics, fentanyl REMS products, and dronabinol products. Please send in a hard copy prescription for controlled medications, and fill in the following blank form for non-controlled medications.
MEDICATION:_____ SIG: _____ QTY: ____ REFILLS: ____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

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

By signing this form and utilizing our services, you are authorizing QuickRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.