HealthQuest Infusion & Specialty

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ORAL ONCOLOGY REFERRAL FORM

E-SCRIPTS: NCPDP# 5902944 NPI# 1720383003

DATE ____________ DATE NEEDED ____________

SHIP TO: ☐ Patient ☐ Physician's Office ☐ HealthQuest Infusion

Please fax completed form along with copy of patient's insurance cards and any labs to 866.612.3437

Patient Name ______________________________
Patient Address ______________________________
City ______________ State ________ Zip ________
Day Phone ______________ Work Phone # ______________
Cell Phone ______________ E-mail ______________
Date of Birth ______________ SS # ______________
☐ Female
☐ Male

Prescriber's Name ______________________________
License # ______________ DEA # ______________
NPI # ______________ UPIN # ______________
Practice Name ______________________________
Office Contact ______________________________
Address ______________________________ Suite # ________
City ______________ State ________ Zip ________
Phone ______________ Fax ______________

DIAGNOSIS

Patient: Wt.__________ Ht.__________ Allergies: ☐ Latex ☐ Other, specify ______________________________

ICD-10 DIAGNOSIS CODE ☐ 152.9 Gastrointestinal Stromal Tumors ☐ 153–154 Metastatic Colorectal Cancer
☐ 155.0 Hepatocellular Carcinoma ☐ 157.9 Adenocarcinoma of Pancreas ☐ 162.9 Pulmonary Malignancy ☐ 174.0 Breast Cancer
☐ 189.0 Renal Cell Carcinoma ☐ 191.9 Glioblastoma ☐ 193.0 Malignant Neoplasm of Thyroid Gland
☐ 202.0 Cutaneous T-Cell Lymphoma ☐ 203.0 Multiple Myeloma ☐ 205.1 Chronic Myeloid Leukemia
☐ 695.2 Erythema Nodosum (ENL) ☐ Other: ______________________________

Renal Dysfunction? ☐ Yes ☐ No **Liver Dysfunction?** ☐ Yes ☐ No
Has patient previously been treated for this condition? ☐ Yes ☐ No **Cancer Stage:** ☐ 0 ☐ I ☐ II ☐ III ☐ IV
☐ Other: ______________________________
Patient currently on therapy? ☐ Yes ☐ No Medications: ______________________________
Patient will stop taking above medications before starting new medication? ☐ Yes ☐ No Washout period: ______________

PRESCRIPTION

SOLID TUMORS

☐ Afinitor® ☐ Inlyta® ☐ Sutent® ☐ Tykerb® ☐ Zolinza®
☐ Afinitor Disperz® ☐ Iressa® ☐ Sylatron® ☐ Votrient® ☐ Other: ______________
☐ Arimidex® ☐ Mekinist® ☐ Tafinlar® ☐ Xalkori®
☐ Erivedge® ☐ Nexavar® ☐ Tagrisso® ☐ Xeloda®
☐ Femara® ☐ Nolvadex® ☐ Tarceva® ☐ Xtandi®
☐ Hycamtin® ☐ Stivarga® ☐ Temodar® ☐ Zykadia®

LIQUID TUMORS

☐ Bosulif® ☐ Farydak® ☐ Jadenu® ☐ Sprycel® ☐ Zydelig®
☐ Exjade® ☐ Gleevec® ☐ Jakafi® ☐ Tasigna® ☐ Other: ______________

Strength/Directions (Sig) ______________________________
Quantity ______________ Refills ______________
Additional Medications: ☐ Pomalyst® ☐ Thalomid® ☐ Revlimid® ☐ Dexamethosone®
Supportive Medications: ☐ Aranesp® ☐ Arixtra® ☐ Emend® ☐ Granix® ☐ Lovenox® ☐ Neulasta® ☐ Neupogen®
☐ Nplate® ☐ Procrit® ☐ Promacta® ☐ Sancuso® ☐ Xgeva® ☐ Zarxio® ☐ Zofran® ☐ Other: ______________
Strength/Directions (sig) ______________________________
Quantity ______________ Refills ______________

PRESCRIBER'S SIGNATURE (Signature required. No stamps.) ______________________________ **DATE** ______________

IMPORTANT NOTICE: This fascimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, propietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee.