Oncology Prescription Referral Form

Phone: 732-885-1000 **Fax: 732-980-0357**

10 Plainfield Ave., Suite 1, Piscataway, New Jersey 08854 www.carepointpharmacynj.com

Patient Information OR Attach Face Sheet

First Name :	Middle Initial :	Last Name :	
Date of Birth :	Gender: ◯ M ◯ F	SSN :	
Street Address :	City :	State :	Zip Code :
Home Phone :	Work Phone :	Cell Phone :	

Insurance Information OR Attach Insurance Information

Rx Card Insurance Name:	ID#:	BIN:	PCN:	Phone #:
Primary Insurance Name:	ID#:		GROUP #:	Phone #:
Secondary Insurance Name:	ID#:		GROUP:	Phone #:

Prescription Information

POMALYST Dosing:	REVLIMID Dosing:	THALOMID Dosing:	Risk Category
◯ 1mg ◯ 2mg ◯ 3mg ◯ 4mg	◯ 10mg ◯ 15mg ◯ 20mg ◯ 25mg	◯ 50mg ◯ 100mg ◯ 150mg ◯ 200mg	☐ Adult Female, NOT of Reproductive Potential
Directions: ____	Directions: ____	Directions: ____	☐ Adult Female, Reproductive Potential
Qty: __ Rest Period: ____	Qty: __ Rest Period: ____	Qty: __ Rest Period: ____	☐ Adult Male
Auth number: ____	Auth number: ____	Auth number: ____	☐ Male Child
Date: ____	Date: ____	Date: ____	☐ Female Child, NOT of Reproductive Potential
Confirmation: ____	Confirmation: ____	Confirmation: ____	☐ Female Child, Reproductive Potential
Date: ____	Date: ____	Date: ____	

Drug List

☐ Afinitor	☐ Sutent	STRENGTH:
☐ Bosulif	☐ Sylatron	
☐ Emend	☐ Tafinlar	
☐ Erivedge	☐ Tarceva	SIG/DIRECTIONS /CYCLE :
☐ Farydak	☐ Tasigna	
☐ Gleevec	☐ Temodar	
☐ Ibrance	☐ Tykerb	
☐ Inlyta	☐ Votrient	
☐ Intron A	☐ Xalkori	
☐ Jadenu	☐ Xeloda	
☐ Mekinist	☐ Xtandi	
☐ Nexavar	☐ Zelboraf	
☐ Promacta	☐ Zykadia	REFILLS:
☐ Sprycel	☐ Zytiga	QUANTITY:
☐ Stivarga	☐ Other	

Secondary Prescription - Drug Name:	Dose:	
Directions/Cycle:	Quantity:	Refills:

Clinical Information

Primary Diagnosis:	ICD - 10 :		
Secondary Diagnosis:	ICD - 10 :	Weight:	Height:
Allergies:		Failed Therapies:	
Patient Medication List (or attach separately):			

Prescriber Information

Prescriber First Name:		Prescriber Last Name:		Facility Name:
DEA:	State License #:	NPI:	UPIN:	Office Contact E-mail:
Office Address:		City:	State:	Zip Code:
Office Phone:		Office Fax:	Office Contact Name:	

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*

Prescriber Signature: **Date:**

Prescriber must write “Brand Medically Ne cessary” in own handwriting to prevent substitution