**Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy.

AccuSERV PHARMACY

ONCOLOGY REFERRAL FORM

Start Date:

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Ship To: ☐ Patient ☐ Office ☐ Other

1. Patient Information: Please fax front and back copy of the insurance card (Prescription and Medical)

Patient: _____ Male / Female DOB: _____ Soc. Sec. #_____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical information: Please fax recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis/ICD-10 (C00-D49) _____

Patient Type (if applicable):

☐ adult female NOT of reproductive potential ☐ child female NOT of reproductive potential

☐ adult female of reproductive potential ☐ child female of reproductive potential Date: _____

BRAF mutation present (if applicable): ☐ V600E ☐ V600K Any prior treatment: ☐ No ☐ Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ☐ NKDA ☐ Other: _____

3. Prescription Information: If you need a medication not listed please contact us

Oncolytics:

☐ Afinitor®	☐ Folotyn®	☐ Lupron®	☐ Tabloid®	☐ Votrient®
☐ Arimidex®	☐ Gleevec®	☐ Lysodren®	☐ Tamoxifen®	☐ Xeloda®
☐ Emcyt®	☐ Hycamtin®	☐ Matulane®	☐ Targretin®	☐ Yervoy®
☐ Empliciti®	☐ Intron A®	☐ Opdivo®	☐ Tasigna®	☐ Zolinza®
☐ Etoposide®	☐ Keytruda®	☐ Sprycel®	☐ Temodar	☐ Zykadia™
☐ Femara®	☐ Lomustine® (Ceenu®)	☐ Sylatron®	☐ Tykerb®	☐ Other:

Strength/Directions (SIG):

Refill # :

Strength/Directions (SIG):

Refill # : **QTY:**

BRAF mutation present:

☐ Mekinist® ☐ V600E

☐ Tafinlar® ☐ V600K

Authorization # :

☐ AccuPac

Supportive Medications:

☐ Aranesp®	☐ Granix®	☐ Neupogen®	☐ Promacta®	☐ Zofran®
☐ Arixtra™	☐ Lovenox®	☐ Nplate®	☐ Sancuso®	☐ Other:
☐ Emend®	☐ Neulasta®	☐ Procrit®	☐ Zarxio™	

Strength/Directions (SIG):

Refill # : **QTY:**

Strength(s): _____ Directions: _____

Quantity: _____ Refills: _____ **Authorization: _____

Packaging: ☐ Normal ☐ AccuPac™

4. Prescriber and Shipping Information

Prescriber (print)_____**Office Contact:**_____

Preferred method of contact: ☐ **phone** ☐ **fax** ☐ **email** **preferred contact persons email:**_____

Office Address:_____

Phone:_____**fax:**_____**NPI:**_____**DEA:**_____

Prescriber's Signature: _____**Date:**_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process (NO STAMPS)

5. Patient Support Programs (optional): Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature:_____**Date:**_____

6. Insurance Information: Please fax a copy of the insurance card (front & back)