ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

Date Needed _____

ONCOLOGY REFERRAL FORM

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

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

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

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

ICD-10 Diagnosis Code: ☐ _____ Weight _____ BSA _____m^2
Allergies _____ Comorbidities _____
Biopsy? ☐ Yes ☐ No Results _____
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **AFINITOR® tablets** ☐ 2 mg ☐ 2.5 mg ☐ 5 mg ☐ 7.5 mg ☐ 10 mg
☐ **ARIMIDEX® tablets** ☐ 1 mg
☐ **AROMASIN® tablets** ☐ 25 mg
☐ **GLEEVEC® tablets** ☐ 100 mg ☐ 400 mg
☐ **HYCAMTIN® tablets** ☐ 0.25 mg ☐ 1 mg
☐ **JADENU® tablets** ☐ 90 mg ☐ 180 mg ☐ 360 mg
☐ **JAKAFI® tablets** ☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg
☐ **MATULANE® capsules** ☐ 50 mg
☐ **NEXAVAR® tablets** ☐ 200 mg
☐ **RYDAPT® capsules** ☐ 25 mg
☐ **SPRYCEL® tablets** ☐ 20 mg ☐ 50 mg ☐ 70 mg ☐ 80 mg ☐ 100 mg ☐ 140 mg
☐ **STIVARGA® tablets** ☐ 40 mg
☐ **SUTENT® capsules** ☐ 12.5 mg ☐ 25 mg ☐ 37.5 mg ☐ 50 mg
☐ **TAMOXIFEN® tablets** ☐ 20 mg
☐ **TARCEVA® tablets** ☐ 25 mg ☐ 100 mg ☐ 150 mg
☐ **TASIGNA® capsules** ☐ 150 mg ☐ 200 mg
☐ **THALOMID® capsules** ☐ 50 mg ☐ 100 mg ☐ 150 mg ☐ 200 mg
☐ **TYKERB® tablets** ☐ 250 mg
☐ **VOTRIENT® tablets** ☐ 200 mg
☐ **XELODA® tablets** ☐ 150 mg ☐ 500 mg
☐ **XTANDI® capsules** ☐ 40 mg
☐ **ZOLINZA® capsules** ☐ 100 mg
☐ **ZYTIGA™ tablets** ☐ 250 mg ☐ 500 mg
SIG: _____ QTY: _____ REFILLS: _____

☐ **ETOPOSIDE® solution** ☐ 100 mg/5 mL ☐ 500 mg/25 mL ☐ 1 g/50 mL | **capsules** ☐ 50 mg
☐ **HERCEPTIN®** ☐ 150 mg vial ☐ 420 mg multi-dose vial
☐ **RITUXAN®** ☐ 100 mg/ 10mL vial ☐ 500 mg/ 50mL vial
☐ **TEMODAR® capsules** ☐ 5 mg ☐ 20 mg ☐ 100 mg ☐ 140 mg ☐ 180 mg ☐ 250 mg | **powder** ☐ 100 mg
SIG: _____ **QTY:** _____ **REFILLS:** _____

SUBSYS® SUBLINGUAL SPRAY (Fentanyl) *REMS and Hard Copy Required*
☐ Initial Dose: 100 mcg
☐ Maintenance Dose: ☐ 200 mcg ☐ 400 mcg ☐ 600 mcg ☐ 800 mcg ☐ 1200 mcg ☐ 1600 mcg
SIG: _____ QTY: _____ REFILLS: _____

FIRMAGON® (Degarelix for injection) ☐ 120 mg vial ☐ 80 mg vial
☐ STARTER DOSE: 240 mg is given as two injections of 120 mg each subcutaneously
☐ MAINTENANCE DOSE: Inject 80 mg subcutaneously as a single injection every 28 days
QTY: _____ REFILLS: _____

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

☐ **NEUPOGEN®** ☐ 300mcg/0.5ml PFS ☐ 480mcg/0.8ml PFS
☐ 300mcg/ml Vial ☐ 480mcg/1.6ml Vial
☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other
☐ Daily x _____ days ☐ Every week ☐ BIW ☐ TIW
☐ **NEULASTA®** 6mg/0.6ml ☐ PFS kit ☐ Solution for injection
☐ **PROCRIT®** ☐ 2,000 units/ml ☐ 3,000 units/ml ☐ 4,000 units/ml
☐ 10,000 units/ml ☐ 20,000 units/ml ☐ 40,000 units/ml
☐ Other_____ SIG: Administer _____ units SQ Weekly
☐ **ARANESP®** ☐ 25 mcg/ml ☐ 40mcg/ml ☐ 60mcg/ml ☐ 100mcg/ml
☐ 150mcg/ml ☐ 200mcg/ml ☐ 300mcg/ml Dosage_____
☐ **RELISTOR®** ☐ 8mg PFS ☐ 12mg PFS ☐ 150mg TABLET
SIG:Administer 1 dose every other day as needed (max 1 dose per 24 hours)
☐ **OTHER** _____
QTY: _____ REFILLS: _____

☐ **IBRANCE** Sig: QD with food for 21 days, then 7 days off QTY: 21 Refills: _____
Sig: ☐ w/ Letrozole: 1 tablet (2.5 mg) QD QTY: 28 Refills: _____

SYNDROS® ☐ 5mg oral solution *Hard Copy Required*
Patient Weight _____(kg) and Height _____ Required
SIG: 4.2mg/m^2 1-3 hours prior to chemotherapy & then every 2-4 hours after chemotherapy for treatment cycle. QTY: _____

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

☐ **ANTIEMETICS** ☐ **CHEMO-INDUCED N/V**
☐ **PROMETHAZINE** ☐ **COMPAZINE** ☐ **EMEND®** ☐ **ZOFRAN®**
☐ **SANCUSO® TRANSDERMAL PATCH** ☐ **OTHER** _____
SIG: _____
DOSAGE: _____ 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**_____

Please fax completed referral form to
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.