



CEDRA

ONCOLOGY ORAL MEDICATIONS

REFERRAL FORM

FAX: 888.889.7129

TOLL FREE: 844.233.7279

CEDRASPECIALTY.COM

PATIENT INFORMATION

Patient Name: DOB: Preferred Phone: SSN#: Language: English Other Address: Sex: Male Female Height: Weight: lbs kg City: State: Zip: Known Allergies:

\* PLEASE FAX FRONT/BACK COPY OF PHARMACY BENEFIT CARD, MEDICAL INSURANCE CARD, LABS & TESTS WITH THE PRESCRIPTION TO EXPEDITE PROCESSING \*

PRESCRIBER INFORMATION

Prescriber Name: DEA#: NPI#: Tax ID#: Address: Phone: E-mail: City: State: Zip: Key Contact: Phone: Fax: STATUS UPDATE PREFERENCE: Phone Text Fax E-mail:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis (ICD-10): BSA: m^2 Code: Description: Code: Description:

PRESCRIPTION INFORMATION

MEDICATION:

Table with 4 columns: Medication Name, Physician Auth #, Date, Diagnosis. Rows include REVLIMID REMS™ Program\*, POMALYST REMS™ Program, and THALOMID REMS™ Program.

Pregnancy Category:

Table with 3 columns: Adult Female - Reproductive Potential, Adult Female - NOT of Reproductive Potential, Adult Male. Rows include Female Child - Reproductive Potential and Female Child - NOT of Reproductive Potential.

Table with 4 columns listing various oral cancer medications such as AFINITOR®, IRESSA®, SPRYCEL®, TYKERB®, etc.

\*Currently may be unavailable from Cedra Specialty. We will assist you and your doctor in obtaining this medication(s).

Table for Rx 1, Rx 2, and Rx 3 with columns for Drug Name/Strength, Quantity, Sig, Refills, and Strength.

Date Medication Needed: Deliver To: Patient Home MD Office

Prescriber Signature: (Please sign and date below) Your signature authorizes Cedra Pharmacy to act on your behalf to obtain prior authorization for the prescribed medications.

Substitution Permissible Date Dispense as written "DAW" Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws.

