DELMARVA SPECIALTY PHARMACY AT WOODBROOKE

ONCOLOGY PRESCRIPTION REFERRAL FORM

1615 Tree Sap Court Salisbury, MD 21804
Tel 410.677.0561 Fax 410.677.0562

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis Code Weight Allergies BSA m^2

Biopsy ☐ Yes ☐ No Results Patient currently on therapy ☐ Yes ☐ No Date of next blood work

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

☐ **Afinitor**	☐ **Sutent**	☐ **Votrient 200mg**
☐ **Arimidex**	☐ **Sprycel**	☐ **Zoladex**
☐ **Aromasin**	☐ **Stivarga**	☐ **Zolinza**
☐ **Etoposide**	☐ **Tamoxifen**	☐ **Xeloda**
☐ **Gleevec**	☐ **Tarceva**	☐ **Xtandi**
☐ **Herceptin**	☐ **Tasigna**	☐ **Zytiga**
☐ **Hycamtin**	☐ **Temodar**	☐ _____
☐ **Matulane**	☐ **Thalomid**	☐ _____
☐ **Nexavar**	☐ **Tykerb 250mg**	☐ _____

Strength _____

SIG _____

QTY _____ **Refills** _____

☐ **Antiemetics** ☐ Chemo-induced N/V

☐ **Compazine** ☐ **Emend** ☐ **Zofran** ☐ **Sancuso Transdermal Patch** ☐ **Other**

Sig Dosage QTY Refills

☐ **Neupogen**	☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other Daily x _____days Every week ☐ BIW ☐ TIW	QTY	Refills
☐ **Neulasta**	Dosage	QTY	Refills
☐ **Procrit**	☐ 40,000 units SQ Weekly ☐ Other	QTY	Refills
☐ **Aranesp**	Dosage	QTY	Refills
☐ **Neumega** 5mg vial	☐ 12.5mg ☐ 25mg ☐ 50mg ☐ 75mg ☐ 100mg	QTY	Refills
☐ **Promacta**		QTY	Refills
☐ **Other**	Dosage	QTY	Refills

By signing this form and utilizing our services, you are authorizing Delmarva Specialty and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

Please fax completed referral form to **Delmarva Specialty Pharmacy** at **410.677.0562** Visit us at **WWW.DELMARVAPHARMACY.COM** for online fillable forms.