ONCOLOGY Prescription Referral Form

4915 BRAODWAY, NEW YORK, NY 10034, TEL: 212-304-4646
FAX: 212-304-0759, Toll Free Number: 1-844-295-8203,
Email: inwoodpharma@gmail.com, Web: www.inwoodpharmacy.com

PATIENT INFORMATION

Patients Name :	SSN#:			DOB:	
Address:	City:	State:		Zip:	
Home Phone:	Cell Phone:	Height:	Weight:	Gender: Male Female	
Email Address:	Diagnosis Code:				

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	P hone:
Secondary Insurance Co:	RxBIN:	RxPCN:	RxGroup:	RxID:	Phone:

DIAGNOSIS/CLINICAL INFORMATION

To expedite prior authorization services, please FAX current and past Chemo regimen(s)/schedule, last clinical notes and/or lab values/scans

Diagnosis: _____ ICD-10: *(required for Medicare B billing)* _____ BSA _____ m^2

Renal Dysfunction: Yes No Current SCr _____ or current GFR _____ml/min

Liver Dysfunction: Yes No

Abnormal Lab Value(s) _____ H/H (Hemoglobin/Hematocrit): _____

Confirmed Mutations: EGFR ALK BRAF V600E BRAF V600K Other:_____

PRESCRIPTION INFORMATION (or attach copy of your script)

REVLMID
Dosing:

☐ 5mg ☐ 10mg
☐ 15mg ☐ 25mg

Directions:
☐ Take _____mg by mouth once a day on day 1-21, of a 28 day cycle.

☐ Others

Qty. | Refills

THALOMID
Dosing:

☐ 5Omg ☐ 100mg
☐ 150mg ☐ 200mg

Directions:
☐ Take _____mg by mouth once a day at bedtime.

☐ Others

Qty: ☐ 4 Week Supply | **No Refills**

POMALYST
Dosing:

☐ 1mg ☐ 2mg
☐ 3mg ☐ 4mg

Directions:
☐ Take _____mg by mouth once a Daily on day 1-21,of a 28 day cycle.

☐ Others

Qty. | Refills

FEMALE
Adult female, not of Reproductive Potential
Adult female, Reproductive Potential
Female Child, not of Reproductive Potential
Female Child, Reproductive Potential

Male
o Adult male o male Child
Celgene Auth #:_____
Date Issued_____
Confirmation #: _____
Date Issued: _____

AFINITOR	o PROCRIT
ARANESP	o RITUXAN
AVASTIN	o SPRYCEL
BOSULIF	o STIVARGA
HERCEPTIN	o SUTENT
IBRANCE	o SYLATRON
LETROZOLE	o TAFINLAR
INLYTA	o TARCEA
GLEEVEC	o TARGRETIN
JADNU	o TASIGNA
KADCYLA	o TEMODAR
MEKINIST	o TYKERB
NEULASTA	o VOTRIENT
NEUPOGEN	o XALkORI
NEXAVAR	o XELODA
PERJETA	o ZYTIGA
PROMACTA	o ZOLINZA

*****Please use this section for additional directions or other medications not listed.*****

STRENGHT

SIG/DIRECTIONS

Qty. | Refills

Prescriber Name:	Phone:	Fax:	
Office Address:	Email:	NPI#:	
DEA#:	LIC#:	☐ Dispense as written:	Date
Prescriber Signature :		Deliver To : ☐ M D Office	☐ Patient Home

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed Medications. We will also pursue available copay and financial assistance on behalf of your patients.