ORAL ONCOLOGY REFERRAL FORM

CALIFORNIA SPECIALTY™ PHARMACY

Physicians must fax the completed referral form to California Specialty Pharmacy at 866-853-6555

Your CSP Rep: _____ and Tel: _____

PATIENT INFORMATION:	PHYSICIAN INFORMATION: Ship to: ■Physician's Office ☐Patient's Home
Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: _____ Alternate Phone: _____	Office Phone: _____ Fax: _____
Email: _____	Email: _____
Date of Birth: _____ Soc. Sec# _____ BSA: _____	Key Office Contact: _____
Sex: ☐ *Male* ☐ *Female* Weight: ____ ☐*lbs* ☐*Kgs* Height: ____ ☐*cm* ☐*ft*	State LIC# _____ NPI# _____ DEA# _____
Allergies: _____	

INSURANCE INFORMATION: ☐ DEMOGRAPHIC SHEET ☐ UNIVERSAL CLAIM FORM ☐ INSURANCE CARDS (front + back)

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

ICD10:		Diagnosis:	

ORAL ONCOLYTICS			
☐ **Afinitor®** (everolimus)	☐ **Inlyta®** (axitinib)	☐ **Temodar®** (temozolomide)	**Dose/QTY/Directions:**
☐ **Alecensa®** (alectinib)	☐ **Kisqali®** (ribociclib)	☐ **Tykerb®** (lapatinib)	
☐ **Alkeran®**(melphalan)	☐ **Lonsurf®** (trifluridine, tipiracil)	☐ **VePesid®** (etoposide)	
☐ **Arimidex®** (anastrozole)	☐ **Lorbrena®** (lorlatinib)	☐ **Vizimpro®** (dacomitinib)	
☐ **Aromasin®** (exemestane)	☐ **Mekinist®** (trametinib)	☐ **Votrient®** (pazopanib)	
☐ **Cotellic™** (cobimetinib)	☐ **Myleran®** (busulfan)	☐ **Xalkori®** (crizotinib)	
☐ **Cytoxan®** (cyclophosphamide)	☐ **Nilandron®** (nilutamide)	☐ **Xgeva ®** (denosumab)	
☐ **Emcyt®** (estramustine)	☐ **Ninlaro®** (ixazomib)	☐ **Xtandi®** (enzalutamide)	
☐ **Erivedge®** (vismodegib)	☐ **Nolvadex®** (tamoxifen citrate)	☐ **Yonsa®** (abiraterone acetate)	
☐ **Exjade® (**deferasirox**)** *Generic*	☐ **Odomzo®** (sonidegib)	☐ **Zelboraf®** (vemurafenib)	
☐ **Farydak®** (panobinostat)	☐ **Purixan®** (mercaptopurine, 6-MP)	☐ **Zolinza®** (vorinostat)	
☐ **Faslodex®** (fulvestrant)	☐ **Rydapt®** (midostaurin)	☐ **Zykadia™** (ceritinib)	
☐ **Femara®** (letrozole)	☐ **Sprycel®** (dasatinib)	☐ **Zytiga®** (abiraterone acetate)	
☐ **Gleevec®** (imatinib)	☐ **Tafinlar®** (dabrafenib)	☐ **Other**	**Refills:**
☐ **Gleostine®** (lomustine)	☐ **Tarceva®** (erlotinib)		
☐ **Hycamtin®** (topotecan)	☐ **Targretin®** (bexarotene)		
☐ **Ibrance®** (palbociclib)	☐ **Tasigna®** (nilotinib)		

ANCILLARY MEDICATIONS		
☐ **Akynzeo®** - (Netupitant/ Palonosetron)	☐ **Lovenox®** (enoxaparin)	**Dose/QTY/Directions:**
☐ **Aranesp®** (darbepoetin alfa)	☐ **Neulasta®** (pegfilgrastim)	
☐ **Arixtra®** (fondaparinux)	☐ **Neupogen®** (filgrastim)	
☐ **Benadryl®** (diphenhydramine)	☐ **Nivestym®**(filgrastim-aafi)	
☐ **Deltasone®** (Prednisone)	☐ **Procrit®** (epoetin alfa)	
☐ **Emend®** (aprepitant)	☐ **Retacrit®** (epoetin alfa-epbx)	
☐ **Fulphila ®**(pegfilgrastim-jmdb)	☐ **Sancuso®** (granisetron)	
☐ **Granix®** (tbo-filgrastim)	☐ **Xgeva ®** (denosumab)	Refills:
☐ **Jadenu®** (deferasirox)	☐ **Zofran®** (ondansetron)	
☐ **Jadenu® Sprinkle** (deferasirox)	☐ **Other**	

Per state-specific law, prescriptions will be dispensed as generic, If applicable, unless noted otherwise: _____

*Prescriber Signature Required *Prescription is void if the number of drugs prescribed is not noted*

I authorize California Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5