COOKEVILLE REGIONAL MEDICAL CENTER
It's the Way WeCARE

ONCOLOGY REFERRAL FORM

FOR INFORMATION
Specialty Services: (931) 783-5551
Fax referral #: (931) 783-5533
Outpatient Pharmacy
931-783-2552 phone
931-783-2553 fax

Referral Info

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:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign:

REVLIMID®
Dosing:
❑5 mg ❑10 mg
❑15 mg ❑25 mg
Directions:
❑ Take _____caps by mouth once a day on days 1-21, of a 28 day cycle.
Qty: _____ No Refills

THALOMID®
Dosing:
❑50 mg ❑100 mg
❑150 mg ❑200 mg
Directions:
❑ Take _____ caps by mouth once daily at bedtime.
Qty: _____ No Refills

POMALYST®
Dosing:
❑1 mg ❑2 mg
❑3 mg ❑4 mg
Directions:
❑ Take _____ caps by mouth once a day on days 1-21, of a 28 day cycle.
Qty: _____ No Refills

CAPECITABINE (XELODA)
Dosing:
❑150 mg ❑500 mg
❑Take ___tabs by mouth two times a day on days 1-14 of 21 day cycle. Repeat.
❑Conjunction with radiation: Start Date:_____ for _____# of days a week.
❑Other _____
Qty: _____ Refills: _____

TEMOZOLOMIDE (TEMODAR)
Dosing:
❑_____ mg
❑Take _____mg by mouth daily for _____days with _____ days off
❑Conjunction with radiation: Start Date:_____ for _____# of days a week.
❑Other _____
Qty: _____ Refills: _____

IMATINIB (GLEEVEC)
Dosing:
❑100 mg ❑400 mg
❑Take ___tabs by mouth once a day
❑Other _____
Qty: _____ Refills: _____

Female
❑ Adult Female, Not of Reproductive Potential
❑ Adult Female, Reproductive Potential
❑ Female Child, Not of Reproductive Potential
❑ Female Child, Reproductive Potential

Male
❑ Adult Male ❑ Male Child

Celgene Auth #: _____
Date Issued: _____
Confirmation #: _____
Date Issued: _____

❑ AFINITOR®
❑ ARANESP®
❑ AVASTIN®
❑ BOSULIF®
❑ ERLEADA™
❑ FARYDAK®
❑ HERCEPTIN®
❑ IBRANCE®
❑ LETROZOLE
❑ INLYTA®
❑ JADENU™
❑ KADCYLA™
❑ KEYTRUDA®
❑ KISQALI®
❑ LORBRENA®
❑ MEKINIST™
❑ NEULASTA®
❑ NEUPOGEN®
❑ NINLARO®
❑ ODOMZO®
❑ OPDIVO®
❑ PERJETA™
❑ PROCRIT®
❑ RITUXAN®
❑ RYDAPT®
❑ SPRYCEL®
❑ SUTENT®
❑ SYLATRON®
❑ TAFINLAR®
❑ TARCEVA®
❑ TARGRETIN®
❑ TASIGNA®
❑ TYKERB®
❑ VIZIMPRO®
❑ VOTRIENT®
❑ XALKORI®
❑ YONSA
❑ ZYTIGA®
❑ ZOLINZA™
❑ ZYKADIA™

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

❑ OTHER

STRENGTH:

SIG/DIRECTIONS

QUANTITY: | **REFILLS:**

Start of Therapy Date:

Special Delivery Instructions:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact/Faxed By:		Email:	
NPI#:	TAX ID#:	Ship To: ❑ Patient ❑ MD Office all Orders	
Prescriber Signature ❑ Dispense as written	Date:		

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.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.