ONCOLOGY REFERRAL FORM A-J

Patient Information

Patient Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F
Phone: ______________ Cell Phone: ______________ Email Address: ______________
Address: ______________________ City: ______________ State: ________ Zip: ____________
ICD-10 Diagnosis Code: ______________ Diagnosis: ______________________
Allergies (please note reaction): ______________________ ☐ Latex
Current Medications: (list here or attach a medication list): ______________________
____
Comorbidities: (list here or attach a list): ______________________

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Anastrozole	1mg Tab	Take 1 tablet by mouth once daily.	☐ 30 tablets ☐ ____tablets	
☐ Exemestane	25mg Tab	Take 1 tablet by mouth once daily after a meal.	☐ 30 tablets ☐ ____tablets	
☐ Fulvestrant	500mg/10mL solution	☐ Inject 500mg intramuscularly on days 1, 15, 29 then monthly thereafter.	_____vials	

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Prescriber Information

Prescriber Name: ______________________________
State License #: ______________ DEA #: ______________ NPI: ______________
Additional Contact Person Name: ______________________
Group or Hospital: ______________________ Phone: ______________
Fax: ______________ Email Address: ______________________
Address: ______________________ City: ______________ State: ________ Zip: ____________

Prescriber Signature: ______________________ ______________________ ____________
Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: ____________

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ONCOLOGY REFERRAL FORM K-L

Patient Information

Patient Name: ____________________ DOB: ____________ Sex: ☐ M ☐ F
Phone: ____________ Cell Phone: ____________ Email Address: ____________
Address: ____________________ City: ____________ State: ______ Zip: ________
ICD-10 Diagnosis Code: ____________ Diagnosis: ____________________
Allergies (please note reaction): ____________________ ☐ Latex
Current Medications: (list here or attach a medication list): ____________________
____
Comorbidities: (list here or attach a list): ____________________

Prescription Information

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Keytruda (pembrolizumab)	☐ 50mg lyophilized powder in SDV for reconstitution	☐ Administer 200mg via intravenous infusion every 3 weeks over 30 minutes.	_____vials	
	☐ 100 mg/4ml solution in single-dose vial	☐ Pediatrics: At 2mg/kg (max. 200mg), administer__________mg via intravenous infusion every 3 weeks over 30 minutes.V		
☐ Kisqali (ribociclib)	200mg Tab	☐ Take 600mg (3 tablets) by mouth once daily for 21 days followed by 7 days off treatment.	☐ 63 tablets	
		☐ Take 400mg (2 tablets) by mouth once daily for 21 days followed by 7 days off treatment.	☐ 42 tablets	
		☐ Take 200mg (1 tablet) by mouth once daily for 21 days followed by 7 days off.	☐ 21 tablets	
☐ Kisqali Femara Co-pack (ribociclib and letrozole)	200mg Tab/ 2.5mg Tab	☐ Take Kisqali 600mg (3 tablets) by mouth once daily for 21 consecutive days followed by 7days off treatment and take Femara 2.5mg (1 tablet) by mouth once daily continuously for a 28-day cycle. ☐ Take Kisqali 400mg (2 tablets) by mouth once daily for 21 consecutive days followed by 7 days off treatment and take Femara 2.5mg (1 tablet) by mouth once daily continuously for a 28-day cycle. ☐ Take Kisqali 200mg (tablet) by mouth once daily for 21 consecutive days followed by 7 days off treatment and take Femara 2.5mg (1 tablet) by mouth once daily continuously for a 28-day cycle.	☐ 91 tablets (one 600mg/2.5mg dose pack) ☐ 70 tablets (one 400mg/2.5mg dose pack) ☐ 49 tablets (one 200mg/2.5mg dose pack)	
☐ Letrozole	2.5mg Tab	☐ Take 1 tablet by mouth once daily. ☐ Take 1 tablet by mouth twice daily.	☐ 30 tablets ☐ 60 tablets ☐ _____tablets	

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: ____________________
State License #: ____________ DEA #: ____________ NPI: ____________
Additional Contact Person Name: ____________________
Group or Hospital: ____________________ Phone: ____________
Fax: ____________ Email Address: ____________________
Address: ____________________ City: ____________ State: ______ Zip: ________

Prescriber Signature: ____________________ Product Substitution Permitted ____________________ Dispensed as Written ____________ Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: ____________

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ONCOLOGY REFERRAL FORM M-Z

Patient Information

Patient Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F
Phone: ______________ Cell Phone: ______________ Email Address: ______________
Address: ______________________ City: ______________ State: ________ Zip: __________
ICD-10 Diagnosis Code: ______________ Diagnosis: ______________________
Allergies (please note reaction): ______________________ ☐ Latex
Current Medications: (list here or attach a medication list): ______________________
____
Comorbidities: (list here or attach a list): ______________________

INSURANCE INFORMATION – FAX COPY OF PATIENT'S INSURANCE CARD – BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Rydapt (midostaurin)	☐ 25mg Cap	☐ Take 100mg by mouth twice daily. ☐ Take 50mg twice daily.	☐ 240 capsules ☐ 120 capsules ☐ ___ capsules	
☐ Verzenio (abemaciclib)	☐ 50mg Tab	Take 1 tablet by mouth twice daily.	☐ 56 tablets ☐ _____tablets	
	☐ 100mg Tab	Take 1 tablet by mouth twice daily.	☐ 56 tablets ☐ _____tablets	
	☐ 150mg Tab	Take 1 tablet by mouth twice daily.	☐ 56 tablets ☐ _____tablets	
	☐ 200mg Tab	Take 1 tablet by mouth twice daily.	☐ 56 tablets ☐ _____tablets	
☐ Zytiga (abiraterone)	☐ 250mg Tab ☐ 500mg Tab	Take _________mg by mouth once daily without food.	☐ _____tablets	
☐ WITH prednisone	5 mg Tab	☐ Take 1 tablet by mouth once daily with food. ☐ Take 1 tablet by mouth twice daily.	☐ 30 tablets ☐ 60 tablets ☐ ____tablets	
Other Medication:				

Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

Prescriber Information

Prescriber Name: ______________________________
State License #: ______________ DEA #: ______________ NPI: ______________
Additional Contact Person Name: ______________________________
Group or Hospital: ______________________ Phone: ______________
Fax: ______________ Email Address: ______________________
Address: ______________________ City: ______________ State: ________ Zip: __________

Prescriber Signature: ______________________ ______________________ ______________
Product Substitution Permitted — Dispensed as Written — Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy Date Medication Needed: ____________

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