Biologics

McKesson Specialty Health

Hematology Prescription Referral Form

Fax: 800.823.4506 Phone: 800.850.4306, option 2

To ensure your patient receives his/her medication as soon as possible, please complete and fax this form, with the patient's relevant treatment history and clinic notes to support the prior authorization process.

☐ **Contact Prescriber with results of benefits investigation before initiating dispense or contacting patient.**

PATIENT INFORMATION

Full Name_____ Gender ☐ M ☐ F DOB_____ Social Security #_____

Shipping Address_____ City_____ State_____ Zip_____

Home Phone_____ Alternate Phone_____

Alternate Contact_____ Relationship_____

Alternate Contact Phone_____ **Oncology Care Model Patient** ☐ YES ☐ NO

INSURANCE INFORMATION

Please include a copy of the front and back of the patient's medical and prescription insurance cards.

CLINICAL INFORMATION

ICD-10 Code_____ Primary Diagnosis/Stage_____

Height_____ Weight_____ Allergies_____

Prior Therapies_____

_____

Reasons for Discontinuation_____ Year_____

Is patient receiving oral steroids? ☐ YES ☐ NO If yes, give dose/duration: Prednisone_____ Dexamethasone_____

Notes_____

List other medications that are being administered as part of this chemotherapy regimen including dose and duration.

_____

PRESCRIBER INFORMATION

Hospital/Clinic_____ Office Contact_____

Address_____ City_____ State_____ Zip_____

Phone_____ Fax_____ Tax ID_____

Prescriber Names	DEA #	NPI #
☐		
☐		
☐		
☐		
☐		

PRESCRIPTION INFORMATION

Rx Start Date_____ **Rx Sent Via** ☐ fax ☐ escribe

- ☐ Bosulif® (bosutinib)
- ☐ Gleevec® (imatinib mesylate)
- ☐ Iclusig® (ponatinib)
- ☐ Idhifa® (enasidenib)
- ☐ Imbruvica® (ibrutinib)
- ☐ Jakafi® (ruxolitinib)
- ☐ Ninlaro® (ixazomib)
- ☐ Pomalyst® (pomalidomide)
- ☐ Revlimid® (lenalidmide)
- ☐ Rydapt® (midostaurin)
- ☐ Sprycel® (dasatinib)
- ☐ Tasigna® (nilotinib)
- ☐ Thalomid® (thalidomide)
- ☐ Venclexta® (venetoclax)
- ☐ Zydelig® (idelalisib)
- ☐ Other _____

Strength_____ Quantity_____ # of Refills_____

For Revlimid, Thalomid and Pomalyst

Patient Type:

☐ FEMALE ☐ Adult ☐ Child

Of Reproductive Potential? ☐ Yes ☐ No

Date of Pregnancy Test _____

☐ MALE ☐ Adult ☐ Child

Authorization #_____ Date_____

Confirmation #_____ Date_____

Directions_____ Brand Medically Necessary? ☐ YES ☐ NO

Prescriber Signature (No Stamps)_____ **Date**_____

Please attach a separate prescription if this form does not comply with your state's prescription law.

OPSG.4.1.083017