Oncology
Prescription Referral Form
Bushnell: Phone: 1.352.793.8000
Fax: 1.352.793.8007
Wildwood: Phone: 1.352.748.9900
Fax: 1.352.748.9902

SAFE SCRIPT PHARMACY
Bushnell | Wildwood
www.safescriptpharmacy.com

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:

4. Prescription Information:

☐ **Afinitor®** (everolimus)	☐ **Gleevec®** (imatinib)	☐ **Rubraca™** (rucaparib)	☐ **Venclexta** (venetoclax)
☐ **Afinitor® Disperz** (everolimus)	☐ **Hycamtin®** (topotecan)	☐ **Rydapt®** (midostaurin)	☐ **Votrient®** (pazopanib)
☐ **Allopurinol**	☐ **Iressa®** (gefitinib)	☐ **Sprycel®** (dasatinib)	☐ **Xeloda®** (capecitabine)
☐ **Arimidex®** (anastrozole)	☐ **Jadenu™** (deferasirox)	☐ **Sylatron®** (peginterferon alfa-2b)	☐ **Xtandi®** (enzalutamide)
☐ **Cabometyx®** (cabozantinib)	☐ **Jakai®** (ruxolitinib)	☐ **Tafinlar®** (dabrafenib)	☐ **Zelboraf®** (vemurafenib)
☐ **Cotellic™** (cobimetinib)	☐ **Kisqali®** (ribociclib)	☐ **Tarceva®** (erlotinib)	☐ **Zykadia™** (ceritinib)
☐ **Dexamethasone®** (dexamethasone)	☐ **Mekinist®** (trametinib)	☐ **Tasigna®** (nilotinib)	☐ **Zolinza®** (vorinostat)
☐ **Exjade®** (deferasirox)	☐ **Ninlaro®** (ixazomib)	☐ **Temodar®** (temozolomide)	☐ **Zytiga®** (abiraterone)
☐ **Farydak®** (panobinostat)	☐ **Nolvadex®** (tamoxifen)	☐ **Tykerb®** (lapatinib)	Generic ☐
☐ **Femara®** (letrozole)	☐ **Odomzo®** (sonidegib)	☐ **Verzenio™** (abemaciclib)	Casodex ☐
			Lupron ☐

Please use this section for additional directions or other medications not listed
☐ OTHER:
STRENGTH:
DIRECTIONS (SIG):
QUANTITY: **REFILLS:**
Start of Therapy Date: **Special Delivery Instructions:**

SUPPORTIVE MEDICATIONS

☐ **Aranesp®** (darbepoetin alfa)	☐ **Lovenox®** (enoxaparin)	☐ **Procrit®** (epoetin alfa)	☐ **Zarxio®** (filgrastim-sndz)
☐ **Arixtra®** (fondaparinux)	☐ **Neulasta®** (pegfilgrastim)	☐ **Promacta®** (eltrombopag)	☐ **Zofran®** (ondansetron)
☐ **Emend®** (aprepitant)	☐ **Neupogen®** (filgrastim)	☐ **Sancuso®** (granisetron)	
☐ **Granix®** (tbo-filgrastim)	☐ **Nplate®** (romiplostim)	☐ **Xgeva®** (denosumab)	

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☐ OTHER:
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IVIG THERAPY: (Please attach prescription)

☐ **Privigen®**	☐ **Hizentra®**	☐ **Gammagard®**	☐ **Gammunex®-C**

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize SafeScript Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

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