Padek Healthcare
Quality Care From The Pharmacists You Trust
PHARMACY

# Padek Healthcare Oncology Prescription Referral Form

5403 A Annapolis Rd Bladensburg, MD 20710
Tel 301-277-7107 | Fax 301-277-7127

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name _____ DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

ICD-10 Diagnosis Code _____ Weight _____ Allergies _____ BSA _____ $m^2$

Biopsy ☐ Yes ☐ No Results _____ Patient currently on therapy ☐ Yes ☐ No Date of next blood work _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

## PRESCRIPTION

☐ **Afinitor** ☐ **Etoposide** ☐ **Sprycel** ☐ **Tasigna** ☐ **Other** _____

☐ **Arimidex** ☐ **Gleevec** ☐ **Tamoxifen** ☐ **Xeloda** ☐ **Other** _____

☐ **Aromasin** ☐ **Sutent** ☐ **Temodar** ☐ **Zoladex** ☐ **Other** _____

Strength _____

SIG _____

QTY _____ Refills _____

☐ **Mugard**

SIG _____

QTY _____ Refills _____

☐ **Other** _____

Strength _____

SIG _____

QTY _____ Refills _____

## PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **Neupogen** ☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other

Daily x _____days ☐ Every week ☐ BIW ☐ TIW

☐ **Neulasta**

☐ **Procrit** ☐ 40,000 units SQ Weekly

☐ **Aranesp** Dosage _____

☐ **Neumega** 5mg vial Dosage _____

☐ **Other** _____

QTY _____ Refills _____

## ANTIEMETICS

☐ **Promethazine** ☐ **Compazine** ☐ **Emend** ☐ **Zofran**

☐ **Sancuso Transdermal Patch** ☐ **Other** _____

Sig _____

Dosage _____ QTY _____ Refills _____

By signing this form and utilizing our services, you are authorizing Padek Healthcare and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

**Prescriber's Signature** (signature required. NO STAMPS) _____ **Date** _____



**PLEASE FAX COMPLETED REFERRAL FORM TO PADEK HEALTHCARE AT 301-277-7127**