

# Oncology

Patient information	Prescriber + shipping information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID #: _____ <b>Please fax a copy of front and back of the insurance card(s).</b>	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber : <input type="checkbox"/> 1st Month <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical information (Please fax all pertinent clinical and lab information)			
<b>Diagnosis/ICD-10 (C00-D49):</b> _____ Patient Type (if applicable): <input type="checkbox"/> adult female NOT of reproductive potential <input type="checkbox"/> child female NOT of reproductive potential    Date: _____ <input type="checkbox"/> adult female of reproductive potential <input type="checkbox"/> child female of reproductive potential BRAF mutation present (if applicable): <input type="checkbox"/> V600E <input type="checkbox"/> V600K    Any prior treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (provide information below)			
Prior Therapy _____ _____ _____	Reason for Discontinuation of Therapy _____ _____ _____	Approximate Start Date _____ _____ _____	Approximate End Date _____ _____ _____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription
<p><b>**To order an Oncology medication, please either fill out the prescription below OR fax a separate prescription with this referral form**</b></p> <p>Drug/Dose/Route/Frequency: _____                      _____                      _____</p> <p>Quantity to Dispense: _____</p> <p>Refills: _____</p>

Prescriber's Signature: _____	Date: _____
I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription.	

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