RE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Oncology IV Referral Form

Send your Rx to: (optional)
Select Location

Date Medication Needed: _____ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-Up (store location): _____ Injection training by pharmacy? ☐

1) Patient & Insurance Information

Please include copies of the FRONT and BACK of ALL insurance cards (prescription and medical) with this fax.

Patient Name: _____ Birth Date: _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐lbs. ☐kgs.
Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____ BSA: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance Info: _____ Policy Number: _____

2) Prescriber Information

Provider Name: _____ DEA #: _____ NPI #: _____ Tax ID#: _____
Address: _____ Phone: _____ Fax: _____
City, State, Zip: _____ Key Contact: _____ Phone: _____

3) Diagnosis/Clinical Information

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Has patient previously been treated for this condition? ○ Yes ○ No Is patient currently on therapy? ○ Yes ○ No
Current Medications: _____
Will patient stop taking the above medication(s) before the new medication? ○ Yes ○ No Diagnosis (ICD-10 code): _____

4) Prescription Information

☐ **Opdivo® (Nivolumab)** ☐ **Opdivo® + Yervoy (Ipilimumab)**

MD Specialty: ☐ Oncologist ☐ Others: _____

Diagnosis:

☐ Metastatic NSCLC (Apply as applicable)
- ☐ Squamous NSCLC ☐ Non Squamous NSCLC ☐ Unknown
- ☐ EGFR mutation positive ☐ ALK mutation positive
- ☐ Without EGFR/ALK mutation

Prior failed platinum or TKI therapy: _____

☐ Metastatic/Advanced Renal Cell Carcinoma
Prior failed anti-angiogenic therapies: _____
- ☐ Sunitinib ☐ Sorafenib ☐ Pazopanib ☐ Everolimus
- ☐ Bevacizumab ☐ Axitinib ☐ Temsirolimus Date: _____

☐ Classical Hodgkin Lymphoma
Relapse/progression after autologous hematopoietic stem cell transplant:
○ Yes ○ No
Post transplantation brentuximab (Adcetris): ○ Yes ○ No

☐ Advanced Small Cell Lung Cancer

☐ Metastatic Squamous Cell head and Neck Cancer:
Current Nasopharyngeal Cancer: ○ Yes ○ No
Prior platinum failed therapy: _____

☐ Advanced/Metastatic Urothelial Carcinoma
Prior platinum failed therapy: _____

☐ Metastatic Colorectal Cancer (dMMR – MSI-H)
Prior platinum failed therapy: _____

☐ Hepatocellular Carcinoma
Previously treated with Nexavar: ○ Yes ○ No
Child – Pugh Class: _____

Age (18 or older): ○ Yes ○ No

Current/past Medical History: (Apply as applicable)

☐ Lung Problems Indicate: _____
☐ Liver Problems Indicate: _____
☐ Lupus ☐ Organ Transplant ☐ Crohn's Disease Ulcerative Colitis
☐ Sarcoidosis ☐ Diabetes

Thyroid Problems:
☐ Hyperthyroidism ☐ Hypothyroidism

Current medication list including OTC meds, herbal supplements and vitamins:
_____
Allergy: _____
Pregnant: ○ Yes ○ No Breastfeeding: ○ Yes ○ No

Dosing and Frequency:
As Monotherapy:
- Flat Dose: ☐ 240mg IV q 2 weeks ☐ 480mg IV q 4weeks
- Wt. Based Dose: ☐ 3mg/kg IV every 2 weeks over 60mins

Combination Therapy:
- Opdivo 1mg/kg IV followed by Yervoy 3mg/kg IV on the same day
- Opdivo 3mg/kg IV followed by Yervoy 1mg/kg IV on the same day

Dosage Forms (all in single dose vials) and Strengths:
☐ 40mg/4ml ☐ 100mg/10ml ☐ 240mg/24ml

Lab Results: Please provide all lab results
☐ CBC ☐ Thyroid: TSH and Free T4 ☐ LFTs ☐ Scr: _____ mg/dl

5) Prescriber Signature

Prescriber, please sign and date below.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ Dispense as written _____ Date _____ Substitution Permissable _____ Date

#of Prescriptions

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.