ST.JUDE
SPECIALTY PHARMACY
& MEDICAL SUPPLIES

ONCOLOGY PRESCRIPTION REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

Patient Name First Name ______ Middle Name ______ Last 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-9 Diagnosis Code ______ Allergies ______ BSA ______ m^2
Biopsy ☐ Yes ☐ No Results ______ Patient currently on therapy ☐ Yes ☐ No Date of next blood work ______

INSURANCE INFORMATION Please fax copy of insurance card (front & back)

Prescriber's Name ______ Office Contact ______
Street Address ______ Suite # ______ City ______ State ______ Zip ______
Tel ______ Fax ______ Email ______
License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **Afinitor**	☐ **Gleevec**	☐ **Tamoxifen**	☐ **Xtandi**
☐ **Avastin**	☐ **Herceptin**	☐ **Tarceva**	☐ **Yervoy**
☐ **Arimidex**	☐ **Hycamtin**	☐ **Tasigna**	☐ **Zelboraf**
☐ **Aromasin**	☐ **Nexavar**	☐ **Tykerb** 250mg	☐ **Zoladex**
☐ **Docetaxel**	☐ **Promacta**	☐ **Temodar**	☐ **Zolinza**
☐ **Erbitux**	☐ **Rituxan**	☐ **Thalomid***	☐ **Zometa**
☐ **Eloxatin**	☐ **Sutent**	☐ **Velcade**	☐ **Zytiga**
☐ **Etoposide**	☐ **Sprycel**	☐ **Votrient** 200mg	
☐ **Erivedge**	☐ **Stivarga**	☐ **Xclair**	**Thalimid**
☐ **Folotyn**	☐ **Sylatron**	☐ **Xeloda**	***Authorization #** ______

Strength ______
SIG ______
QTY ______ **Refills** ______

☐ **XGEVA** Strength: 120 mg/1.7 mL (70 mg/mL) single-use vial QTY ______ Refills ______
☐ 120 mg SQ every 4 weeks in the upper arm, upper thigh, or abdomen
☐ 120 mg SQ every 4 weeks in the upper arm, upper thigh, or abdomen Additional 120 mg doses on days 8 and 15 of the first month of therapy

☐ **Antiemetics** ☐ Chemo-induced
☐ **Compazine** ☐ **Emend** ☐ **Zofran** ☐ **Sancuso Transdermal Patch** ☐ **Other**
Dosage ______ QTY ______ Refills ______

☐ **Neupogen**
☐ 300 mcg SQ ☐ 480 mcg SQ ☐ Other ______ QTY ______ Refills ______
☐ Daily x ____ days ☐ Every week ☐ BIW ☐ TIW

☐ **Procrit** ☐ 40,000 units SQ Weekly ☐ Other ______ QTY ______ Refills ______

☐ **Aranesp**	☐ **Caphosol**	☐ **Nplate**	☐ **Zofran**
☐ **Neumega** 5mg vial	☐ **Kytrel**	☐ **Neulasta**	☐ ______
☐ **Arixtra**	☐ **Lovenox**	☐ **Promacta**	☐ ______

Dosage ______ Sig ______ QTY ______ Refills ______

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

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