HAWAII SPECIALTY™ PHARMACY

ORAL ONCOLOGY REFERRAL FORM

Please complete and attach to MDX prior Authorization form

MDX Hawai'i

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alternate Phone:	Phone: Fax:
Email:	Office Email:
Soc. Sec #: Sex: ☐ Male ☐ Female BSA:	Key Office Contact
Date of Birth: Weight: ☐lbs ☐Kg Height: ☐ft ☐cm	State LIC # NPI # DEA#
Allergies:	

INSURANCE INFORMATION: ☐ **DEMOGRAPHIC SHEET** ☐ **UNIVERSAL CLAIM FORM** ☐ **INSURANCE CARDS (front + back)**

**Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)*

ICD-10:	**Diagnosis:**

ORAL ONCOLYTICS

			Dose/QTY/Directions:
☐ **Afinitor®** (everolimus)	☐ **Jadenu®** (deferasirox)	☐ **Temodar®** (temozolomide)	
☐ **Alecensa®** (alectinib)	☐ **Kisqali®** (ribociclib)	☐ **Tykerb®** (lapatinib)	
☐ **Alkeran®**(melphalan)	☐ **Lonsurf®** (trifluridine, tipiracil)	☐ **VePesid®** (etoposide)	
☐ **Arimidex®** (anastrozole)	☐ **Mekinist®** (trametinib)	☐ **Votrient®** (pazopanib)	
☐ **Aromasin®** (exemestane)	☐ **Myleran®** (busulfan)	☐ **Xalkori®** (crizotinib)	
☐ **Bosulif®** (bosutinib)	☐ **Nilandron®** (nilutamide)	☐ **Xeloda®** (capecitabine)	
☐ **Cotellic™** (cobimetinib)	☐ **Ninlaro®** (ixazomib)	☐ **Yonsa®** (abiraterone acetate)	
☐ **Cytoxan®** (cyclophosphamide)	☐ **Nolvadex®** (tamoxifen citrate)	☐ **Zelboraf®** (vemurafenib)	
☐ **Emcyt®** (estramustine)	☐ **Odomzo®** (sonidegib)	☐ **Zolinza®** (vorinostat)	
☐ **Erivedge®** (vismodegib)	☐ **Purixan®** (mercaptopurine, 6-MP)	☐ **Zykadia™** (ceritinib)	
☐ **Farydak®** (panobinostat)	☐ **Rydapt®** (midostaurin)	☐ **Zytiga®** (abiraterone acetate)	
☐ **Femara®** (letrozole)	☐ **Sprycel®** (dasatinib)	☐ **Other**	
☐ **Gleevec®** (imatinib)	☐ **Sutent®** (sunitinib)		
☐ **Gleostine®** (lomustine)	☐ **Tafinlar®** (dabrafenib)		
☐ **Hycamtin®** (topotecan)	☐ **Tarceva®** (erlotinib)		**Refills:**
☐ **Ibrance®** (palbociclib)	☐ **Targretin®** (bexarotene)		
☐ **Inlyta®** (axitinib)	☐ **Tasigna®** (nilotinib)		

ANCILLARY MEDICATIONS

		Dose/QTY/Directions:
☐ **Akynzeo®** - (Netupitant/ Palonosetron)	☐ **Neulasta®** (pegfilgrastim)	
☐ **Aranesp®** (darbepoetin alfa)	☐ **Neupogen®** (filgrastim)	
☐ **Arixtra®** (fondaparinux)	☐ **Procrit®** (epoetin alfa)	
☐ **Benadryl®** (diphenhydramine)	☐ **Sancuso®** (granisetron)	
☐ **Deltasone®** (Prednisone)	☐ **Zarxio®** (filgrastim)	
☐ **Emend®** (aprepitant)	☐ **Zofran®** (ondansetron)	
☐ **Granix®** (tbo-filgrastim)	☐ **Other**	
☐ **Jadenu®** (deferasirox)		**Refills:**
☐ **Lovenox®** (enoxaparin)		

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	**DATE**	
x		**NO. OF DRUGS PRESCRIBED** ___________ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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