IRVINGTON PHARMACY

ONCOLOGY PRESCRIPTION REFERRAL FORM

1070 Springfield Ave, Irvington, NJ 07111
Phone : 862-255-2804 | Fax : 860-229-2417
E-mail : irvingtonpharmacy@gmail.com

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-9 Code Allergies BSA m^2

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

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

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Additional 120 mg doses on days 8 and 15 of the first month

☐ **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

PLEASE NOTE: Riverfront Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.