BERGEN AVE DRUGS
Specialty Pharmacy

ONCOLOGY PRESCRIPTION REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306
Tel 201.521.0545 | Fax 201.521.0546

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

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-10 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**	☐ **Glivec**	☐ **Tasigna**
☐ **Avastin**	☐ **Herceptin**	☐ **Temodar**
☐ **Aromasin**	☐ **Kadcyla**	☐ **Velcade**
☐ **Docetaxel**	☐ **Opdivo**	☐ **Xeloda**
☐ **Erbitux**	☐ **Rituxan**	☐ **Yervoy**
☐ **Eloxatin**	☐ **Sivextro**	☐ **Zolinza**
☐ **Etoposide**	☐ **Sprycel**	☐ **Zometa**
☐ **Gleevec (Imatinib)**	☐ **Sylatron**	☐

Strength

SIG

QTY **Refills**

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

☐ **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**	☐
☐ **Neumega** 5mg vial	☐ **Zofran**	☐
☐ **Arixtra**	☐	☐

Dosage Sig QTY Refills

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

Please fax completed form to **Bergen** at **201.521.0546**

Visit us at **WWW.BERGENDRUGS.COM** for online fillable forms.