

BERGEN AVE DRUGS ONCOLOGY PRESCRIPTION REFERRAL FORM

Specialty Pharmacy

745 Bergen Ave | Jersey City, NJ, 07306

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Today's Date

NEW PATIENT CURRENT PATIENT

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

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 _____ m²

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

<input type="checkbox"/> Afinitor	<input type="checkbox"/> Glivec	<input type="checkbox"/> Tasigna
<input type="checkbox"/> Avastin	<input type="checkbox"/> Herceptin	<input type="checkbox"/> Temodar
<input type="checkbox"/> Aromasin	<input type="checkbox"/> Kadcyca	<input type="checkbox"/> Velcade
<input type="checkbox"/> Docetaxel	<input type="checkbox"/> Opdivo	<input type="checkbox"/> Xeloda
<input type="checkbox"/> Erbitux	<input type="checkbox"/> Rituxan	<input type="checkbox"/> Yervoy
<input type="checkbox"/> Eloxatin	<input type="checkbox"/> Sivextro	<input type="checkbox"/> Zolanza
<input type="checkbox"/> Etoposide	<input type="checkbox"/> Sprycel	<input type="checkbox"/> Zometa
<input type="checkbox"/> Gleevec (Imatinib)	<input type="checkbox"/> Sylatron	<input type="checkbox"/> _____

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** _____

Neumega 5mg vial **Zofran** _____

Arixtra _____ _____

Dosage _____ Sig _____ QTY _____ Refills _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

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

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

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