oncology plus

ORAL PRESCRIPTION REFERRAL FORM

FAX 866.833.0509 PHONE 877.410.0779

PRESCRIBER INFORMATION 1

Office Contact Name _____

Today's Date _____ Request Call Back ☐ YES ☐ NO

Prescriber's Name (please print) _____

Name of Hospital/Clinic _____

Hospital/Clinic Street Address _____

City _____ State _____ Zip _____

Phone # _____

Fax # _____

Practice NPI # _____ Provider NPI # _____

Provider's DEA # _____

Provider's Federal Tax ID# _____

Prescriber's State License # _____

PATIENT INFORMATION 2

Full Name _____

Gender ☐ M ☐ F DOB _____ SS # _____

Shipping Address _____

City _____ State _____ Zip _____

Home Phone # _____ Alt. Phone # _____

Alternate Contact _____

Relationship _____ Phone # _____

INSURANCE INFORMATION 3

Primary Insurance Name _____

Primary Insurance Phone _____

Primary Insured's Name _____

Relationship _____

ID# _____ Group # _____

BIN # _____ PCN # _____

Medicare Claim # _____ Medicare Part B Effect. Date _____

Part D Benefit _____

Secondary Insurance Name _____

Insured's Name _____ Effective Date _____

ID# _____ Group # _____

CLINICAL INFORMATION 4

Primary Diagnosis _____

ICD9 Code _____

Height _____ Weight _____ BSA _____

Allergies _____

PRESCRIPTION INFORMATION 5

RX Start Date _____

Drug #1 name _____

Frequency _____

_____

Quantity _____ # of Refills _____

Drug #2 name _____

Frequency _____

_____

Quantity _____ # of Refills _____

Drug #3 name _____

Frequency _____

_____

Quantity _____ # of Refills _____

PRN Prescription Name _____

Quantity _____ # of Refills _____

CURRENT MEDICATIONS 6

Analgesic _____

Antiemetic _____

Anticholinergic _____

Other _____

PRESCRIBER PRIOR AUTHORIZATION CONSENT 7

Oncology Plus, Inc. ("OPI") offers oncology pharmacy and related patient services. As such, it has the ability to assist Physicians in expediting patient receipt of and proper administration of specialty oncology drugs prescribed by Physician. In order to take advantage of these support capabilities, Physician hereby authorizes OPI, as agent for Physician, to perform any of the following services on behalf of Physician for the benefit of Physician's oncology patients who are referred to OPI's oncology pharmacy:

- To obtain "prior authorization" from applicable PBMs or other payors ("Payors") for oncology drugs prescribed by Physician, including, as necessary, the provision of prerequisite clinical and other Patient information to the Payor;
- To conduct benefits investigations on behalf of Physician for Patients for oncology drugs prescribed by Physician; and
- To conduct eligibility investigations on behalf of Physician for Patients for oncology drugs prescribed by Physician.

In furtherance of OPI performing the above services, Physician agrees to provide or make available to OPI from time to time such information regarding Patient or Patient's treatment as might be requested by a Payor.

☐ I certify I am prescribing the drug(s) listed above.

☐ I authorize OPI to perform the above referenced services on behalf of Physician for the benefit of the Patient.

Prescriber Signature _____

Name _____ Date _____

COMMENTS/SPECIAL INSTRUCTIONS 8