

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
