60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
beneverepharmacy.com

TODAY'S DATE: ____________

☐ NEW PATIENT ☐ CURRENT PATIENT

ONCOLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name ____________

Address ____________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell ____________

DOB ____________ SSN ____________

Drug Allergies ____________ ☐ Male ☐ Female

Patient Weight: ____________ Height: ____________

PRESCRIBER INFORMATION

Prescriber Name ____________ DEA# ____________

NPI# ____________ Tax ID ____________

Practice Name ____________

Address ____________ Suite ____________

City ____________ State ____________ Zip ____________

Office Phone ____________ Fax ____________

Office Contact ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Prescription Drug Coverage: Company ____________

Secondary Insurance (if applicable) ____________

Policy # ____________ Group ____________

Insurance Phone ____________

Phone ____________

RXGRP# ____________ RXBIN# ____________ PCN/ID# *(if available)* ____________

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE AND PRESCRIPTION BENEFIT CARDS IF AVAILABLE

CLINICAL INFORMATION

Diagnosis ____________ ICD-9 ____________ Date of Dx ____________

Lab Values: WBC ______ ANC ______ Hgb ______ Hct ______ Plate ______ BSA ______ Height ______ Weight ______ lbs or kgs

Please provide brief medical justification (previous treatments, failed therapies, allergies etc) ____________

____

Is patient currently on therapy? ☐ Yes ☐ No Type/medication(s): ____________

Will patient stop taking the above medications before starting the new medication? ☐ Yes ☐ No If yes, what is the washout period? ____________

DRUG NAME	DIRECTIONS FOR USE	QUANTITY	REFILLS
☐ Afinitor®			
☐ Gleevec®			
☐ Sprycel®			
☐ Sutent®			
☐ Temodar®			
☐ Thalomid®			
☐ Xeloda®			

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

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