MedRX Infusion
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MEDRXINFUSION.COM

Date Medication Needed: _____

Ship to: ☐ Patient ☐ Prescriber ☐ Other: _____

☐ Self injection teaching needed

☐ Prescriber's office will teach patient self administration

Oncology Referral Form

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed: 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: _____ Date of birth: _____ height: _____ weight: _____

Address: _____ Allergies/Intolerances: _____

Phone number(s): _____ ☐ No known allergies: _____

Treatment Diagnosis/Problem(s): _____

Prescriber name: _____ Contact person: _____

Office Address: _____

Phone number: _____ Fax number: _____ NPI number: _____

Provide chemotherapy protocol with medication orders, including doses and adjuncts

This is cycle #____ of _____ cycles, cycle length (days or weeks) _____

Therapy is going to be administered ☐ physicians office ☐ infusion suite ☐ in patients home

☐ Home Health care nursing is needed

☐ Patient has an existing intravenous access device (catheter type) _____ date placed _____ and will require Home Health to maintain the intravenous catheter and MedRx to provide supplies needed including NaCl 0.9% flush and Heparin 100units/ml flush per nursing and pharmacy protocol.

Prescription Information for Hemopoetic growth factors for chemotherapy

☐Filgrastim (Neupogen) ☐ vial ☐ pfs _____ mcg, subcutaneously daily for _____ days, starting _____

☐Pegfilgrastim (Neulsta) 6 mg pfs, subcutaneously on day _____ of week _____ of chemotherapy cycle starting _____

☐Epoetin (Procrit, Epogen) vial _____ units subcutaneously _____(frequency) for _____ days, starting _____

☐ Darbepoetin (Aranesp*) ☐ vial ☐ pfs _____ mcg, subcutaneously every ____ weeks for _____ weeks, starting _____
*Prescriber must be enrolled in ESA APPRISE Oncology Program"

☐ Romiplostim (Nplate) ☐ 250 mcg vl ☐ 500 mcg vl: Give_____ mcg subcutaneously every 7 days, for _____ doses

Dispense supplies necessary for administration and hazardous waste disposal.

Physicians Signature:_____ Date: _____