



ONCOLOGY PRESCRIPTION REFERRAL FORM

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943

Email referral form to: connect@realospecialtycare.com

For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ Male Female SS#: _____ DOB: _____
 Address: _____ City, State, Zip: _____
 Primary Phone: _____ Home Cell Work Alternate Phone: _____ Home Cell Work
 Email: _____ Height: _____ Weight: _____
 Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
 Address: _____ City, State, Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: Patient Physician/Clinic Realo Location: _____
 Date Shipment Needed By: _____ Alternate Location: _____
 Shipping Address _____ City, State, Zip _____

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, and tests to expedite PA)

Diagnosis / ICD-10: _____
 Pertinent Lab Information: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
Afinitor® (everolimus)				
Afinitor Disperz® (everolimus)				
Alkeran® (melphalan)				
Farydak® (panobinostat)				
Faslodex® (fulvestrant)				
Gleevec® (imatinib)				
Kisqali® (ribociclib)				
Leukeran® (chlorambucil)				
Lupron® (leuprolide)				
Mekinist® (trametinib)				
Rydapt® (midostaurin)				
Sprycel® (dasatinib)				
Tafinlar® (dabrafenib)				
Targretin® (bexarotene)				
Tasigna® (nilotinib)				
Temodar® (temozolomide)				
Trelstar® (triptorelin)				
Tykerb® (lapatinib)				
Votrient® (pazopanib)				
Xeloda® (capecitabine)				
Xgeva® (denosumab)				
Zytiga® (abiraterone acetate)				

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

_____	_____	_____	_____
Dispense As Written - Signature	Date	Substitution Permissible - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.

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