ONCOLOGY REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

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Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Bosulif (bosutinib)	☐ 100mg Tab	☐ Take 500mg by mouth once daily with food.	30-day supply	
	☐ 500mg Tab	☐ Take _____mg by mouth once daily with food.		
☐ Ibrance (palbociclib)	☐ 75mg Cap	Take 1 capsule by mouth once daily with food for 21 days, followed by 7 days off for a 28 day cycle.	21 caps	
	☐ 100mg Cap			
	☐ 125mg Cap			
☐ WITH letrozole	2.5mg Tab	Take 1 tablet by mouth once daily.	30-day supply	
☐ WITH anastrozole	1mg Tab	Take 1 tablet by mouth once daily.	30-day supply	
☐ WITH exemestane	25mg Tab	Take 1 tablet by mouth once daily after a meal.	30-day supply	
☐ WITH fulvestrant	500mg Sol	☐ Inject 500mg intramuscularly on days 1, 15, 29 then monthly thereafter.	30-day supply	
☐ Inlyta (axitinib)	☐ 5mg Tab	☐ Take 5mg by mouth twice daily, approximately 12 hours apart.	30-day supply	
	☐ 1mg Tab	☐ Take _____mg by mouth twice daily, approximately 12 hours apart.		
☐ Keytruda (pembrolizumab)	☐ 50mg lyophilized powder in SDV for reconstitution	☐ Administer 200mg via intravenous infusion every 3 weeks over 30 minutes.	21-day supply	
	☐ 100 mg/4ml solution in single-dose vial	☐ Pediatrics: At 2mg/kg (max. 200mg), administer _____mg via intravenous infusion every 3 weeks over 30 minutes.V		
☐ Kisqali (ribociclib)	200mg Tab	☐ Take 600mg (3 tablets) by mouth once daily for 21 days followed by 7 days off treatment.	28-day supply	
		☐ Take _____mg by mouth once daily for 21 days followed by 7 days off treatment	28-day supply	
☐ WITH letrozole	2.5 mg Tab	☐ Take 1 tablet by mouth twice daily.	30-day supply	
☐ Kisqali Femara Co-pack (ribociclib and letrozole)	200mg Tab/ 2.5mg Tab	☐ Take Kisqali 600mg (3 tablets) by mouth once daily for 21 consecutive days followed by 7days off treatment and take Femara 2.5 mg by mouth once daily continuously for a 28-day cycle.	28-day supply	

Prescription information continued on next page

Prescription Information - Continued

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Lorbrena (lorlatinib)	☐ 100mg Tab	Take 1 tablet by mouth once daily.	30-day supply	
	☐ 25mg Tab	☐ Take 1 tablet (25mg) by mouth once daily. ☐ Take 2 tablets (50mg) by mouth once daily. ☐ Take 3 tablets (75mg) by mouth once daily.		
☐ Rydapt (midostaurin)	☐ 25mg Cap	☐ Take 100mg by mouth twice daily. ☐ Take 50mg twice daily.	☐ 30-day supply ☐ 90-day supply	
☐ Talzenna (talazoparib)	☐ 1mg Cap	Take 1 tablet by mouth once daily.	30-day supply	
	☐ 0.25mg Cap	☐ Take 1 tablet (0.25mg) by mouth once daily. ☐ Take 2 tablets (0.5mg) by mouth once daily. ☐ Take 3 tablets (0.75mg) by mouth once daily.		
☐ Verzenio (abemaciclib)	☐ 50mg Tab	Take 1 tablet by mouth twice daily.	28-day supply	
	☐ 100mg Tab	Take 1 tablet by mouth twice daily.	28-day supply	
	☐ 150mg Tab	Take 1 tablet by mouth twice daily.	28-day supply	
	☐ 200mg Tab	Take 1 tablet by mouth twice daily.	28-day supply	
☐ Vizimpro (dacomitinib)	☐ 45mg Tab ☐ 30mg Tab ☐ 15mg Tab	Take 1 tablet by mouth once daily.	30-day supply	
☐ Xalkori (crizotinib)	☐ 250mg Cap	☐ Take 250mg by mouth twice daily. ☐ Take 250mg by mouth once daily.	30-day supply	
	☐ 200mg Cap	☐ Take 200mg by mouth twice daily.		
☐ Zytiga (abiraterone)	☐ 250mg Tab ☐ 500mg Tab	Take _____mg by mouth once daily without food.	30-day supply	
☐ WITH prednisone	5 mg Tab	Take 1 tablet by mouth once daily with food.	30-day supply	
☐ WITH prednisone	5 mg Tab	Take 1 tablet by mouth twice daily with food.	30-day supply	
Other Medication:				

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____