KnippeRx™ Specialty Pharmacy Services

Oncology Referral Form

Phone: (855) 647-7379
Fax: (855) 774-3879

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:_____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:_____

1. Patient Information

Last Name: _____ First Name: _____ Home Phone:_____ Work/Mobile Phone:_____

S.S. #: _____ Date of Birth: _____ Home Address:_____

Guardian/Caregiver:_____ City:_____ State:_____ Zip:_____

Patient Preferred Language:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance:_____ Phone:_____ Prescription Card: _____ Phone:_____

Subscriber Name:_____ Policy #:_____ BIN/PCN:_____

Policy #:_____ Group #:_____ Medicare #:_____ Medicaid #:_____

3. Prescriber Information

Prescriber Name:_____ ☐ MD ☐ DO ☐ NP ☐ PA License #:_____ NPI #:_____ DEA #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____ Office Contact:_____ Phone:_____

City: _____ State:_____ Zip:_____ Collaborating Physician:_____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10:_____ Concurrent Medications:_____

Secondary ICD-10:_____

Allergies:_____ Meds Tried & Failed:_____

5. Prescription Information

Temodar: Strength_____, _____, _____

Instructions _____ daily PO

QTY _____ refills _____

Strength _____, _____, _____

Instructions _____ PO daily for 5 days

QTY _____ refills _____

Gleevec: 100mg____

400mg_____

Instructions: _____

QTY _____ refills _____ with a meal and a large glass of water

Xeloda: 150mg_____

500mg_____

Take _____ daily PO with water within 30 min after a meal

QTY _____ refills _____

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date _____ / _____ / _____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize KnippeRx, Inc. to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date _____ / _____ / _____