Oral Chemotherapy Program Referral Form

UK HealthCare
Department of Pharmacy Services
www.UKSpecialtyPharmacy.org

UK Specialty Pharmacy
800 Rose Street HC201
Lexington, KY 40536
Phone 859-218-5413
Fax 859-257-8626

DATE:_____ DELIVER TO CLINIC:_____ MAIL TO PATIENT:____ PICKUP AT KCP:____OTHER:_____

ICD-10 CODE:_____ ANTICIPIATED START DATE:_____

PATIENT INFORMATION ☐Male ☐Female

Name: _____

Address:_____

City, State, Zip: _____

DOB:_____ SSN:_____

Home Phone: _____

Cell/Alternate Phone:_____

SHIPPING INFORMATION ☐ same

Shipping Address:_____

City, State, Zip: _____

Will UPS deliver to your house? ☐ yes ☐ no

Will FedEx deliver to your house? ☐ yes ☐ no

PACKAGING REQUEST

☒ Child Resistant Lids ☐ Easy Open Lids

I certify that all the information on this form is correct , including any selections made for sending my order signature required or with non-child resistant (easy open) caps. I permit UK Specialty Pharmacy to release all information on this form concerning prescription orders to my plan sponsor, administrator, or health plan for the purpose of payment, treatment, or healthcare operations.

Patient Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Patient:_____

Phone Number:_____
(Different from Patient number)

DOCUMENT CHECKLIST (for staff)

- ☐ Medicare Suppliers Standards given
- ☐ UK HealthCare Patient Rights given
- ☐ Notice of Privacy Practices given
- ☐ Insurance Information complete

THIS ASSIGNMENT OF BENEFITS IS FOR:

- ☒ Anti Cancer Meds

This Intake Form is used in lieu of patient's or his/her representative's signature on the HICFA 1500 and on other health insurance claim forms. Any person who misrepresents or falsifies information can be subjected upon conviction to fines and imprisonment. The undersigned certifies that they are the patient, or is duly authorized to execute this consent and accept its terms as or on behalf of the patient and has read the information and understands and agrees to the terms hereof as or on behalf of the patient. The undersigned being the patient or his/her representative desires to purchase the medication or supplies from UK HealthCare Ambulatory Pharmacies.

I have received a copy of the Medicare Suppliers Standards, UK Healthcare Notice of Privacy Practices and Your Rights and Responsibilities as a UK HealthCare Patient. I also acknowledge that I have received instruction/training on the medication and supplies provided to me. I authorize the release of my medical or other information necessary to process the claim. I also request payment of Medicare or insurance benefits to UK HealthCare Ambulatory Pharmacy. I agree to pay all co-payments, deductibles and non-covered services.

Patient Signature: _____ Date: _____

*If Power of Attorney or Spouse is signing on behalf of the patient, please sign Patient's Name **by** Signer's Name (reason patient cannot sign)*

UK Contract Specialty Pharmacy Referral Form
Oncology

UK Specialty Phone 844-730-5913 UK Specialty Fax 859-257-8626

PATIENT INFORMATION:

Patient Name: _____
Last First Middle

Patient Height:_____inches **Patient Weight**:_____kg **Patient Language**:_____

Allergies:_____

Other Medications:_____
_____
_____
(Please provide printed list, if possible)

INSURANCE INFORMATION:
(Please provide copy of card- Front and Back)

Primary Medical Insurance: _____
Plan Name Patient ID Number Plan Phone Number

Primary Prescription Insurance:_____
Plan Name Patient ID Number Plan Phone Number

_____
BIN PCN Rx Group

Supplemental Insurance: _____
Plan Name Patient ID Number Plan Phone Number

SHIPMENT PREFERENCES:

☐ FedEx to Patient: ☐ Home ☐ Apartment
☐ Clinic Pick-Up: ☐First Fill ☐Always: _____
☐ Other (Please Specify) _____

PRESCRIPTION SENT VIA: ☐ FAX ☐ ESCRIBE

CLINICAL INFORMATION:

Primary Diagnosis:_____ _____ ICD- 10 Code: _____

Diagnosis Date:_____ Stage:_____

Prior Therapies/Reason for Discontinuation (with dates):_____

_____

_____

Genetic Testing Results_____

_____

Other Pertinent Information

_____

_____ _____

Fill Type**:** ☐ New Start ☐ Continuation of therapy

Line of Chemotherapy: ☐ Neoadjuvant ☐ Adjuvant ☐ 1st Line ☐ 2nd Line ☐ 3rd Line ☐ Other

Anticipated Chemotherapy Regimen:_____

Anticipated Length of Treatment:_____

Start Date: _____ Days Per Cycle (#):_____

PRESCRIBER INFORMATION:

Prescribing Physician:_____ NPI: _____

Physician Address: _____

Physician Contact Phone #: _____ Office Contact Name:_____

REQUIRED DOCUMENTATION:

Oral Chemotherapy Program Intake Form
Copy of All Insurance Cards (Front and Back)
Copy of clinical notes, pertinent labs, scans, pathology, cytology, etc.
Copy of Prescription
Medicare Assignment of Benefits Form
Signed Permission to Communicate
Signed 3rd Party Release for Copay Assistance
PA Approval (if applicable)

PATIENT MANAGEMENT PROGRAM BY UK SPECIALTY PHARMACY: ☐ Yes ☐ No

By signing below, I choose to opt out of UK Specialty Pharmacy Patient Management Program:
Refill Management will continue.

X _____Date: _____

(patient signature)