UNIVERSAL
• SPECIALTY PHARMACY •

P: 855-900-8414
F: 855-710-7101
NPI: 1427588805
www.rxuniversal.com

Oncology Referral Form

☐ **Urgent/Stat** ☐ **Standard**

Prescriber

Prescriber Information

Prescriber Name:			☐MD ☐PA ☐NP	
NPI:	DEA:		Office Contact:	
Address:				
City:	State:	Zip:	Phone #:	Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:		MI:	Last Name:	
DOB:	Sex: ☐M ☐F	Last 4 Digits SSN :	Interpreter: ☐Y ☐N Specify:	
Address:				
City:	State:	Zip:	Primary #:	Alternate #:
Emergency Contact:	Phone #:	Contact Preference: ☐AM ☐Noon ☐PM		

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

Primary ICD10:	Secondary ICD10:	Diagnosis Date: / /	
Weight: ☐lb/ ☐kg	Height: ☐in/ ☐cm	Allergies:	
Current Medications:			
Prior Therapies:		Diagnosis Date: / /	
Continuity of Care: / /			

Prescription

Prescription Information

Dose Start Date: / / ☐New Prescription ☐Refill Prescription ☐New to Therapy ☐Restarting Therapy

Deliver to: ☐Patient's Home ☐Prescriber's Office ☐Other

Dose/Strength	Directions	Therapy Cycle	Quantity	Refills

☐ Afinitor® ☐ Alecensa® ☐ Alkeran® ☐ Alunbrig® ☐ Bosulif® ☐ Cabometyx® ☐ Cotellic® ☐ Cyclophosphamide® ☐ Erivedge®

☐ Erleada® ☐ Etoposide® ☐ Exjade® ☐ Fareston® ☐ Farydak® ☐ Gleevec® ☐ Gleostine® ☐ Hycamtin® ☐ Ibrance®

☐ Inlyta® ☐ Jakafi® ☐ Kisqali & Femara® ☐ Kisqali® ☐ Leukeran® ☐ Mekinist® ☐ Nexavar® ☐ Nilandron® ☐ Ninlaro®

☐ Odomzo® ☐ Opdivo® ☐ Purixan® ☐ Rydapt® ☐ Sprycel® ☐ Stivarga® ☐ Sutent® ☐ Tabloid® ☐ Tafinlar®

☐ Talzenna® ☐ Tarceva® ☐ Targretin® ☐ Tasigna® ☐ Temodar® ☐ Tretinoin® ☐ Tykerb® ☐ Verzenio® ☐ Vizimpro®

☐ Votrient® ☐ Xalkori® ☐ Xeloda® ☐ Xtandi® ☐ Yonsa® ☐ Zelboraf® ☐ Zolinza® ☐ Zykadia® ☐ Zytiga®

☐ Other

☐ Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

By signing this form and utilizing our services, you are authorizing Universal Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /