



Phone: 1-888-315-3395

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EUSA Pharma

REFERRAL FORM

GENERAL INFORMATION

Patient Information:

Patient's Name: _____

PH: (_____) _____ Alt. PH: (_____) _____

Address: _____

City/State/Zip: _____

Patient's DOB: _____ Sex: M F

Height _____ Weight _____ Social Security No: _____

Emergency Contact: _____

Phone: _____ Allergies: _____

Physician Information:

Physician: _____

State Lic. #: _____ DEA#: _____

NPI #: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Contact: _____

Date Shipment Needed: _____ Ship Meds to: Patient Physician Permission to contact patient? Yes No

INSURANCE INFORMATION

(Please submit a copy of the front and back of the insurance card if possible)

Primary Insurance: _____ Cardholder Name: _____

Relationship: _____ I.D. #: _____ GRP # _____ Phone: _____

Secondary Insurance: _____ Cardholder Name: _____

Relationship: _____ I.D. #: _____ GRP # _____ Phone: _____

PRESCRIPTION

Diagnosis: Mucositis (528.00) Xerostomia (527.7) Other: _____ (ICD Code: _____)

CAPHOSOL® (Supersaturated Calcium Phosphate Rinse)

DIRECTIONS: Use _____ doses per day. May use up to 10 doses per day if needed.

QUANTITY : 1 month supply PRN Refills

STANDARD DOSING:

- For use during high-dose chemotherapy or radiation treatment: 4 doses per day from the onset of the cancer treatment. Up to 10 doses per day if pain from mucositis is experienced. Use for the duration of the treatment or as instructed by physician.

- Relief of dry mouth: 2-10 times per day or as instructed by physician.

Axium Healthcare Pharmacy also provides support medications such as IV meds, oral chemotherapy, blood modifiers, antiemetics and more.

OTHER MEDS (i.e. chemo/blood modifier):

Medication: _____ Sig as directed: _____

Qty: _____ Refill x _____ Months
Generic substitution is mandated unless practitioner writes in the words "NO SUBSTITUTION"

Medication: _____ Sig as directed: _____

Qty: _____ Refill x _____ Months
Generic substitution is mandated unless practitioner writes in the words "NO SUBSTITUTION"

Physician Signature: _____ Date: _____