Genesis
Cancer and Blood Institute
A DIVISION OF AMERICAN ONCOLOGY PARTNERS, P.A.

NEW PATIENT REFERRAL FORM

Referral Fax Number: (855) 324-2799
GenesisCancerBlood.com

REFERRAL TO GENESIS CANCER AND BLOOD INSTITUTE FOR INFUSED NON-ONCOLOGY DRUGS

Please use this form as your cover sheet

Drug to be Infused: _____

Date Required/Needed: _____ **Auth # for Outpatient Facility:** _____

Patient Name: _____ Gender: _____ Ht: _____ Wt: _____

Date of Birth: _____ Contact Phone: _____

Secondary Contact #: _____

REFERRING PHYSICIAN INFORMATION:

Name: First _____ Last _____

Phone: _____ Fax: _____

Genesis Cancer and Blood Institute will contact your patient to arrange initial infusion and schedule return visits. We will fax our office visit notes to the referring physician. We may require assistance from the referring physician in the event of a denial.

Patient will require financial assistance: ☐ Yes ☐ No ☐ Unknown

PLEASE FAX THE FOLLOWING INFORMATION WITH THE REFERRAL TO (855) 324-2799.

- ICD-10 Diagnosis code for infused drug: _____
- Written order for the drug, including SIG, signed by referring physician
- Medical records supporting diagnosis, order for drug, and pertinent labs/diagnostics for the infusion; demographics sheet
- Previously tried and failed treatments for diagnosis resulting in new drug order
- **Copy of insurance card(s) front and back; copy of auth letter/notice from insurance primary and secondary**
- TOUCH program pre-enrollment form as needed (TYSABRI [natalizumab] only)
- REMS Authorization as appropriate (i.e. Lemtrada)

FOR QUESTIONS, PLEASE CALL (501) 624-7700.