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: ______________________ Dosage Instructions: ______________________

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.