

Physician Chemotherapy Drug Replacement/Request Form

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a Representative call **800-588-6767**. Form must be completed for processing.

Patient Name: _____ Keystone Mercy ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Drug to be administered from (on): _____ to _____ Or was administered on: _____ to be replaced by physician's office.
 Diagnosis: _____ ICD-9 Diagnosis Code: _____

Justification for Request for IV 5-HT₃ receptor antagonists instead of ORAL 5-HT₃ _____

Deliver to: Physician's Office Patient's Address Other Location: _____

Physician Signature: _____ Date: _____

Premedications				Doxorubicin mg IV Q X Day(s) or Dose(s)			
Cimetidine	mg IV Q	X	Day(s) or Dose(s)	Etoposide	mg IV Q	X	Day(s) or Dose(s)
Dexamethasone	mg IV Q	X	Day(s) or Dose(s)	Fludarabine	mg IV Q	X	Day(s) or Dose(s)
Diphenhydramine	mg IV Q	X	Day(s) or Dose(s)	Fluorouracil	mg IV Q	X	Day(s) or Dose(s)
Ranitidine	mg IV Q	X	Day(s) or Dose(s)	Gemcitabine	mg IV Q	X	Day(s) or Dose(s)
Antiemetics				Ifosfamide mg IV Q X Day(s) or Dose(s)			
Dolasetron	mg IV Q	X	Day(s) or Dose(s)	Irinotecan	mg IV Q	X	Day(s) or Dose(s)
Metoclopramide	mg IV Q	X	Day(s) or Dose(s)	Methotrexate	mg IV Q	X	Day(s) or Dose(s)
Ondansetron	mg IV Q	X	Day(s) or Dose(s)	Mitomycin	mg IV Q	X	Day(s) or Dose(s)
Prochlorperazine	mg IV Q	X	Day(s) or Dose(s)	Mitoxantrone	mg IV Q	X	Day(s) or Dose(s)
Chemotherapy/Adjuvant Agents				Paclitaxel mg IV Q X Day(s) or Dose(s)			
Amifostine	mg IV Q	X	Day(s) or Dose(s)	Pamidronate	mg IV Q	X	Day(s) or Dose(s)
Bleomycin	mg IV Q	X	Day(s) or Dose(s)	Rituximab	mg IV Q	X	Day(s) or Dose(s)
Carboplatin	mg IV Q	X	Day(s) or Dose(s)	Thiotepa	mg IV Q	X	Day(s) or Dose(s)
Carmustine	mg IV Q	X	Day(s) or Dose(s)	Topotecan	mg IV Q	X	Day(s) or Dose(s)
Cisplatin	mg IV Q	X	Day(s) or Dose(s)	Vinblastine	mg IV Q	X	Day(s) or Dose(s)
Cyclophosphamide	mg IV Q	X	Day(s) or Dose(s)	Vincristine	mg IV Q	X	Day(s) or Dose(s)
Cytarabine	mg IV Q	X	Day(s) or Dose(s)	Vinorelbine	mg IV Q	X	Day(s) or Dose(s)
Dacarbazine	mg IV Q	X	Day(s) or Dose(s)	Interferons			
Docetaxel	mg IV Q	X	Day(s) or Dose(s)	Interferon alfacon-1	µg SCQ	Day(s) or times weekly	X Weeks
				Interferon alfa-2A	IU SCQ	Day(s) or times weekly	X Weeks

Other/Hydration: _____

