



Oncology Rx Referral Form

Hematologic Cancer

SPECIALTY CARE SOLUTIONS

3712 Park Ave. Weehawken, NJ 07086
Phone: (201)552-9500 Fax:(888)332-4494

Info@parkaverx.com www.parkaverx.com
E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: _____ Ship To: Patient's Home Prescriber's Office Or Pick-up from Pharmacy Injection needed by pharmacy? Yes No

1: Patient Information

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.
 Soc. Sec. #: _____ Preferred Phone: _____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Alternate Caregiver Name: _____ Preferred Phone: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Diagnosis/Clinical Information | Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization

Diagnosis: _____ ICD-10: _____
 Complete this section ONLY if you would like Park Avenue Pharmacy to initiate a Prior Authorization of Appeal on your behalf:

Prior therapy	Reason for discontinuation of therapy	Year of discontinuation
	<input type="radio"/> Disease Progression <input type="radio"/> Finished Therapy <input type="radio"/> Toxicity (please specify) _____	

3: Prescriber Information

Prescriber Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____
 Address: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____
 City: _____ State: _____ Zip: _____ Key Contact: _____ Phone: (____) _____ - _____

4: Prescription Information

§ Bosulif®, Calquence®, Farydak®, Gleevec®, IDHIFA®, Imbruvica®, and Jakafi® Ninlaro®, Pomalyst®, Revlimid®, Rydapt®, Sprycel®, Synribo®, Tasigna® and Thalomid® are listed alphabetically on respective enrollment forms §

Medication	Directions	Quantity	Refill
<input type="checkbox"/> Venclexta™ (venetoclax)	<input type="checkbox"/> Take 20 mg once daily during week 1, 50 mg once daily during week 2, 100 mg once daily during week 3, 200 mg once daily during week 4 by mouth with food and water	<input type="checkbox"/> 1 starter pack	0
	<input type="checkbox"/> Take 400 mg by mouth once daily with food and water	<input type="checkbox"/> 120 x 100 mg tablets	
	Patient will be obtaining either Allopurinol or Rasburicase at: <input type="checkbox"/> Park Ave. Pharmacy (fill prescription below) <input type="checkbox"/> Other pharmacy <input type="checkbox"/> Not Receiving (Reason: _____)		
<input type="checkbox"/> Allopurinol			
<input type="checkbox"/> Rasburicase			
<input type="checkbox"/> Zelboraf® (vemurafenib)	<input type="checkbox"/> Take 960mg by mouth twice daily (every 12 hours)	<input type="checkbox"/> 240 x 240 mg tablets	
<input type="checkbox"/> Zolinza® (vorinostat)	<input type="checkbox"/> Take 400 mg by mouth once daily with food	<input type="checkbox"/> 120 x 100 mg tablets	
<input type="checkbox"/> Zydelig® (idelalisib)	<input type="checkbox"/> Take 150 mg by mouth twice daily	<input type="checkbox"/> 60 x 150 mg tablets	

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissible _____ Date _____ Dispense as written _____ Date _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.