SPECIALTY CARE SOLUTIONS

Oncology Rx Referral Form
Breast Cancer

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Phone: (201)552-9500 Fax:(888)332-4494
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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
	O Disease Progression O Finished Therapy O Toxicity (please specify) __________	

3: Prescriber Information

Prescriber Name: __________ DEA#: __________ NPI#: __________ Tax ID#: __________

Address: __________ Phone: (____) ______ - ______ Fax: (____) ______ - ______

City: __________ State: ______ Zip: ______ Key Contact: __________ Phone: (____) ______ - ______

4: Prescription Information

§ Afinitor® and Ibrance® are listed alphabetically on respective enrollment forms.§

Medication	Directions	Quantity	Refill
☐ **Kisqali® (ribociclib)**	☐ Take 600 mg by mouth once daily on days 1-21 of a 28-day cycle ☐ __________ Patient will be obtaining an aromatase inhibitor at: ☐ Park Ave. Pharmacy (fill prescription below) ☐ Other pharmacy ☐ Not receiving (Reason:)	☐ 63 x 200 mg tablets ☐ __________	______
☐ **Kisqali® (ribociclib) Femara® (letrozole) Co-pack**	☐ Take 600 mg of Kisqali® by mouth once daily on days 1-21 with 2.5 mg of Femara® by mouth once daily on days 1-28 of a 28-day cycle. ☐ __________	☐ 63 x 200 mg tablets of Kisqali® 28 x 2.5 mg tablets of Femara® ☐ __________	______
☐ **Nerlynx™ (neratinib)**	☐ Take 240 mg by mouth once daily with food ☐ Take ____ mg by mouth once daily with food	☐ 180 x 40 mg tablets ☐ ______ x 40 mg tablets	______
☐ **Loperamide**	☐ Take 4 mg by mouth three times daily for days 1-14; then take 4 mg by mouth twice daily for days 15-30	☐ 148 x 2 mg capsules	0
	☐ Take 4 mg by mouth twice daily for days 31-56	☐ 104 x 2 mg capsules	0
	☐ Take 4 mg by mouth as needed (not to exceed 16 mg per day)	☐ _____ x 2 mg capsules	______
☐ **Tykerb® (lapatinib)**	☐ Take 1,250 mg by mouth once daily at least one hour before or after a meal ☐ Take 1,500 mg by mouth once daily at least one hour before or after a meal ☐ __________	☐ 105 x 250 mg capsules ☐ 180 x 250 mg capsules ☐ __________	______
☐ **Xeloda® (capecitabine)**	☐ Take ____ mg (____ mg/m2/dose x ____m2) by mouth twice daily (every 12 hours) within 30 minutes after a meal on days 1-14 of a 21-day cycle	☐ _____ x 150 mg capsules ☐ _____ x 500 mg capsules	______
☐ **Femara® (letrozole)**	☐ Take 2.5 mg by mouth once daily	☐ 30 x 2.5 mg tablets	______

Verzenio™ and Xeloda® are listed alphabetically on respective enrollment forms.§

5. Endocrine Therapy Options

Medication	Directions	Quantity	Refill
☐ Evista® (raloxifene) ☐ Fareston® (toremifen) ☐ Nolvadex® (tamoxifen)			
☐ Arimidex® (anastrozole) ☐ Aromasin® (exemestane) ☐ Femara® (letrozole)			
☐ Faslodex® (fulvestran)			

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 Permissable __________ 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.