



Oncology Rx Referral Form

Other Cancers

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

§ Afinitor®, Afinitor®, Disperz, Cometriq®, Gleevec®, Lonsurf® and Nexavar® are listed alphabetically on respective enrollment enrollment forms.§

Medication	Directions	Quantity	Refill
<input type="checkbox"/> Stivarga® (regorafenib)	<input type="checkbox"/> Take 160 mg by mouth once daily with a low-fat meal on days 1-21 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 84 x 40 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Sutent® (sunitinib)	<input type="checkbox"/> Take 50 mg by mouth once daily on days 1-28 of a 42-day cycle <input type="checkbox"/> Take 37.5 mg by mouth once daily <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 50 mg capsules <input type="checkbox"/> 28 x 37.5 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Tarceva® (erlotinib)	<input type="checkbox"/> Take 150 mg by mouth once daily on an empty stomach <input type="checkbox"/> Take 100 mg by mouth once daily on an empty stomach <input type="checkbox"/> Take _____ mg by mouth once daily on an empty stomach	<input type="checkbox"/> 30 x 150 mg tablets <input type="checkbox"/> 30 x 100 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Temodar® (temozolomide)	<input type="checkbox"/> Take _____ mg (75 mg/m ² /day x _____ m ²) by mouth once daily on an empty stomach with a full glass of water on days _____ of a _____-day cycle <input type="checkbox"/> Take _____ mg (150 mg/m ² /day x _____ m ²) by mouth once daily on an empty stomach with a full glass of water on days 1-5 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____	
<input type="checkbox"/> Votrient® (pazopanib)	<input type="checkbox"/> Take 800 mg by mouth once daily on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 120 x 200 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Xeloda® (capecitabine)	<input type="checkbox"/> Take _____ mg (1250 mg/m ² /dose x _____ m ²) by mouth twice daily (every 12 hours) within 30 minutes after a meal on days 1-14 of a 21-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> _____ x 150 mg tablets <input type="checkbox"/> _____ x 500 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Zejula™ (niraparib)	<input type="checkbox"/> Take 300 mg by mouth twice daily on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 90 x 100 mg capsules <input type="checkbox"/> _____	

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.