PARK AVENUE PHARMACY

SPECIALTY CARE SOLUTIONS

Oncology Rx Referral Form
Breast Cancer

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
	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

Medication	Directions	Quantity	Refill
☐ **Afinitor® (everolimus)**	☐ Take 10 mg by mouth once daily with a full glass of water ☐ _____	☐ 28 x 10 mg tablets ☐ _____	_____
☐ **Dexamethasone oral solution 0.5 mg/5mL** *(alcohol free)*	☐ Swish (for two minutes) and spit 10 mL (two teaspoonfuls) four times daily. Avoid eating or drinking for at least one hour after rinse. ☐ _____	☐ 1120 mL ☐ _____	_____
☐ **Ibrance® (palbociclib)**	☐ Take 125 mg by mouth once daily with food on days 1-21 of a 28-day cycle ☐ _____	☐ 21 x 125 mg capsules ☐ _____	_____
	Patient will be obtaining either Femara® or Faslodex® at: ☐ Park Ave. Pharmacy (fill prescription below) ☐ Other pharmacy ☐ Not receiving (Reason: _____)		
☐ **Femara® (letrozole)**	☐ Take 2.5 mg by mouth once daily Ibrance® and Femara® (letrozole) are automatically dispensed in a CarePak™. CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule. ☐ Check here to opt out of CarePak™	☐ 28 x 2.5 mg tablets	_____
☐ **Faslodex® (fulvestrant)**	☐ Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on days 1 and 15	☐ 4 PFS	0
	☐ Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on day 29 then once monthly thereafter	☐ 2 PFS	_____

5. Endocrine Therapy Options

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

§ Kisqali®, Nerlynx™, Tykerb®, Verzenio™ and Xeloda® are listed alphabetically on respective enrollment forms.§

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 _____