SPECIALTY CARE SOLUTIONS

Oncology Rx Referral Form
Hematologic 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
☐ **Bosulif®** **(bosutinib)**	☐ Take 500 mg by mouth once daily with food ☐ ______	☐ 30 x 500 mg tablets ☐ ______	______
☐ **Calquence®** **(acalabrutinib)**	☐ Take 100 mg by mouth every twelve hour ☐ ______	☐ 60 x 100 mg capsules ☐ ______	______
☐ **Farydak®** **(panobinostat)**	☐ Take 20 mg by mouth once daily on days 1, 3, 5, 8, 10 and 12 of a 21-day cycle ☐ ______	☐ 6 x 20 mg capsules ☐ ______	______
☐ **Dexamethasone**	☐ Take 20 mg by mouth once daily with food on days 1, 2, 4, 5, 8, 9, 11, and 12 of a 21-day cycle ☐ ______	☐ 8 x 20 mg capsules ☐ ______	______
☐ **Aspirin**	☐ Take 81 mg by mouth once daily ☐ ______	☐ 28 x 81 mg tablets ☐ ______	______
☐ **Gleevec®** **(imatinib)**	☐ Take 400 mg by mouth once daily with a meal and full glass of water ☐ Take 600 mg by mouth once daily with a meal and full glass of water ☐ Take ______ mg (340 mg/m2/day x ______ m2) by mouth once daily with a meal and full glass of wate ☐ ______	☐ 30 x 400 mg tablets ☐ 30 x 400 mg tablets ☐ 60 x 100 mg tablets ☐ ______	______
☐ **IDHIFA®** **(enasidenib)**	☐ Take 100 mg by mouth once dail ☐ ______	☐ 30 x 100 mg Tablets ☐ ______	______
☐ **Imbruvica®** **(ibrutinib)**	☐ Take 420 mg by mouth once daily with a full glass of water ☐ Take 560 mg by mouth once daily with a full glass of water ☐ ______	☐ 90 x 140 mg Tablets ☐ 120 x 140 mg Tablets ☐ ______	______

§Jakafi®, Ninlaro®, Pomalyst®, Revlimid®, Rydapt®, Sprycel®, Synribo®, Tasigna®, Thalomid® Venclexta™,Zelboraf®, Zolinza®, Zydelig® 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 ______

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.