



Oncology Rx Referral Form

Hematologic Cancer

SPECIALTY CARE SOLUTIONS

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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® are listed alphabetically on respective enrollment forms §

Medication	Directions	Quantity	Refill
<input type="checkbox"/> Rydapt® (midostaurin)	<input type="checkbox"/> Take 50 mg by mouth twice daily with food on days 8-21 of each cycle <input type="checkbox"/> Take 100 mg by mouth twice daily with food <input type="checkbox"/> _____	<input type="checkbox"/> 56 x 25 mg capsules <input type="checkbox"/> 224 x 25 mg capsules <input type="checkbox"/> _____	
<input type="checkbox"/> Sprycel® (dasatinib)	<input type="checkbox"/> Take 100 mg by mouth once daily <input type="checkbox"/> Take 140 mg by mouth once daily <input type="checkbox"/> _____	<input type="checkbox"/> 30 x 100 mg tablets <input type="checkbox"/> 30 x 140 mg tablets <input type="checkbox"/> _____	
Synribo® (omacetaxine mepesuccinate)	To order Synribo® please see the Teva form at http://www.synribohcp.com/pdf/Request_Form.PDF Phone: 844-796-2273 Fax: 855-796-7426		
<input type="checkbox"/> Tassigna® (nilotinib)	<input type="checkbox"/> Take 300 mg by mouth twice daily (every 12 hours) on an empty stomach <input type="checkbox"/> Take 400 mg by mouth twice daily (every 12 hours) on an empty stomach <input type="checkbox"/> _____	<input type="checkbox"/> 112 x 150 mg tablets <input type="checkbox"/> 112 x 200 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Thalomid® (thalidomide)	<input type="checkbox"/> Take 200 mg by mouth once daily with water, preferably at bedtime and at least 1hour after the evening meal <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 200 mg tablets <input type="checkbox"/> _____	0
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Take 40 mg by mouth once daily with food on days 1-4, 9-12 and 17-20 of a 28-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> 12 x 40 mg tablets <input type="checkbox"/> _____	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Take 81 mg by mouth once daily <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 81 mg tablets <input type="checkbox"/> _____	

§ Venclexta™, Zelboraf®, Zolanza®, 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 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.