# Oncology Rx Referral Form
## Hematologic Cancer

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 |
|---|---|---|
| | O Disease Progression<br>O Finished Therapy<br>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

**§ Bosulif®, Calquence®, Farydak®, Gleevec®, IDHIFA®, Imbruvica®, and Jakafi® are listed alphabetically on respective enrollment forms §**

| Medication | Directions | Quantity | Refill |
|---|---|---|---|
| ☐ **Jakafi® (ruxolitinib)** | ☐ Take ______ mg by mouth once daily<br>☐ Take ______ mg by mouth once daily | ☐ 30 x ____ mg tablets<br>☐ 60 x ____ mg tablets | ______ |
| ☐ **Ninlaro® (ixazomib)** | ☐ Take 4 mg by mouth once weekly on days 1, 8, and 15 of a 28-day cycle<br>☐ ______________ | ☐ 3 x 4 mg capsules<br>☐ ______ | ______ |
| ☐ **Pomalyst® (pomalidomide)** | ☐ Take 4 mg by mouth once daily on days 1-21 of a 28-day cycle<br>☐ ______________ | ☐ 21 x 4 mg capsules<br>☐ ______ | 0 |
| ☐ **Dexamethasone** | ☐ Take 40 mg by mouth once daily with food on days 1, 8, 15, and 22 of a 28-day cycle<br>☐ ______________ | ☐ 4 x 40 mg capsules<br>☐ ______ | ______ |
| ☐ **Aspirin** | ☐ Take 81 mg by mouth once daily<br>☐ ______________ | ☐ 28 x 81 mg tablets<br>☐ ______ | ______ |
| ☐ **Check here to dispense Pomalyst® with dexamethasone and/or aspirin in a CarePak™.** CarePak™ is a specially designed package with clearblister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule. | | | |
| ☐ **Revlimid® (lenalidomide)** | ☐ Take 10 mg by mouth once daily<br>☐ Take 25 mg by mouth once daily on days 1-21 of a 28-day cycle<br>☐ ______________ | ☐ 28 x 10 mg capsules<br>☐ 21 x 25 mg capsules<br>☐ ______ | 0 |
| ☐ **Dexamethasone** | ☐ Take 40 mg by mouth once daily with food on days 1, 8, 15, and 22 of a 28-day cycle<br>☐ ______________ | ☐ 4 x 40 mg capsules<br>☐ ______ | ______ |
| ☐ **Aspirin** | ☐ Take 81 mg by mouth once daily<br>☐ ______________ | ☐ 28 x 81 mg tablets<br>☐ ______ | ______ |
| ☐ **Check here to dispense Pomalyst® with dexamethasone and/or aspirin in a CarePak™.** CarePak™ is a specially designed package with clearblister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule. | | | |

**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.