PARK AVENUE PHARMACY

SPECIALTY CARE SOLUTIONS

Oncology Rx Referral Form
Lung 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
☐ **Hycamtin® (topotecan)**	☐ Take _____ mg (2.3 mg/m2/day x _____ m2) by mouth once daily on days 1-5 of a 21-day cycle ☐ _____	☐ ___ x 0.25 mg capsules ___ x 1 mg capsules ☐ _____	_____
☐ **Iressa® (gefitinib)**	☐ Take 250 mg by mouth once daily ☐ _____	☐ 30 x 250 mg tablets ☐ _____	_____
☐ **Mekinist® (trametinib) +**	☐ Take 2 mg of Mekinist® by mouth once daily on an empty stomach ☐ _____	☐ 30 x 2 mg tablets ☐ _____	_____
☐ **Tafinlar® (dabrafinib)**	☐ Take 150 mg of Tafinlar® by mouth twice daily (every 12 hours) on an empty stomach ☐ _____	☐ 120 x 75 mg capsules ☐ _____	_____
☐ **Tagrisso® (osimertini)**	☐ Take 80 mg by mouth once daily ☐ _____	☐ 30 x 80 mg tablets ☐ _____	_____
☐ **Tarceva® (erlotinib)**	☐ Take 150 mg by mouth once daily on an empty stomach ☐ _____	☐ 30 x 150 mg tablets ☐ _____	_____
☐ **Xalkori® (crizotinib)**	☐ Take 250 mg by mouth once daily ☐ _____	☐ 60 x 250 mg capsules ☐ _____	_____
☐ **Zykadia® (ceritinib)**	☐ Take 750 mg by mouth once daily on an empty stomach ☐ _____	☐ 60 x 250 mg capsules ☐ _____	_____

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 _____