Oncology - Breast Cancer Enrollment Form (A-R)

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

ONCBCARRX-20-01

CLINICAL CONSIDERATIONS

☐ ICD10: _____
Diagnosis: _____
Mutation(s): HER2: ☐ Positive ☐ Negative
ER: ☐ Positive ☐ Negative
PR: ☐ Positive ☐ Negative

Past Medical History:

History of therapies tried/failed and reason for discontinuation (please include dates):

Immunization History
☐ Influenza
Date: ____ /____ / ____

℞

Medication	Directions	Quantity	Refills
☐ **Afinitor®** (everolimus)	☐ Take 10 mg by mouth once daily with a full glass of water ☐ Take _____ mg by mouth once daily with a full glass of water	☐ 28 x 10 mg tablets ☐ _____	
☐ **Dexamethasone** oral solution 0.5 mg/5 mL (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. ☐ Other:_____	☐ 5 x 240 mL (1200 mL) ☐ _____	
☐ **Kisqali®** (ribociclib)	☐ Take 600 mg by mouth once daily on days 1-21 of a 28-day cycle ☐ Other:_____	☐ 63 x 200 mg tablets ☐ _____	

Patient will obtain aromatase inhibitor at: ☐ PANTHERx (fill prescription below) ☐ Other Pharmacy ☐ Not receiving (Reason:_____)

☐ **Kisqali® and Femara® Co-Pack** (ribociclib/letrozole)	☐ Take 600 mg of Kisqali® by mouth once daily on days 1-21 with 2.5 mg of Femara® by mouth once daily on days 1-28 of a 28-day cycle ☐ Other:_____	☐ 63 x 200 mg tablets of Kisqali® 28 x 2.5 mg tablets of Femara® ☐ _____	
☐ **Piqray®** (alpelisib)	☐ Take 300 mg (two 150 mg tablets) by mouth once daily with food ☐ Other:_____	☐ 56 x 150 mg tablets ☐ _____	
☐ **Faslodex®** (fulvestrant)	☐ **Initial:** Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on days 1, 15, and 29, then maintenance dose ☐ **Maintenance:** Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes once monthly ☐ Other:_____	☐ ___ x 250 mg/5 mL prefilled syringes (supplied in packages of 2 injections)	

Endocrine Therapy Options

Medication	Directions	Quantity	Refills
☐ **Evista®** (raloxifene)	☐ Take 60 mg by mouth once daily	☐ 30 x 60 mg tablets	
☐ **Fareston®** (toremifene)	☐ Take 60 mg by mouth once daily	☐ 30 x 60 mg tablets	
☐ **Tamoxifen**	☐ Take 20 mg by mouth once daily ☐ Other:_____	☐ _____ x 20 mg tablets ☐ _____ x 10 mg tablets	
☐ **Arimidex®** (anastrozole)	☐ Take 1 mg by mouth once daily	☐ 30 x 1 mg tablets	
☐ **Aromasin®** (exemestane)	☐ Take 25 mg by mouth once daily ☐ Other:_____	☐ 30 x 25 mg tablets ☐ _____	
☐ **Femara®** (letrozole)	☐ Take 2.5 mg by mouth once daily	☐ 30 x 2.5 mg tablets	
☐ **Faslodex®** (fulvestrant)	☐ **Initial:** Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on days 1, 15, and 29, then maintenance dose ☐ **Maintenance:** Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes once monthly ☐ Other:_____	☐ ___ x 250 mg/5 mL prefilled syringes (supplied in packages of 2 injections)	

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ / ____ / ____