Oncology - Breast Cancer Enrollment Form (S-Z)

PRx

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 #: _____

ONCBCSZRX-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
☐ **Tykerb®** (lapatinib)	☐ Take 1,250 mg by mouth once daily at least one hour before or after a meal ☐ Take 1,500 mg by mouth once daily at least one hour before or after a meal ☐ Other:_____	☐ 105 x 250 mg tablets ☐ 180 x 250 mg tablets ☐ _____	
☐ **Xeloda®** (capecitabine)	☐ Take _____ mg (_____ mg/m^2/dose x _____ m^2) by mouth twice daily (every 12 hours) within 30 minutes after a meal on days 1-14 of a 21-day cycle	☐ _____ x 150 mg tablets ☐ _____ x 500 mg tablets	
☐ **Femara®** (letrozole)	☐ Take 2.5 mg by mouth once daily	☐ _____ x 2.5 mg tablets	
☐ **Xeloda®** (capecitabine)	☐ Take _____ mg (_____ mg/m^2/dose x _____ m^2) by mouth twice daily (every 12 hours) within 30 minutes after a meal on days 1-14 of a 21-day cycle ☐ Other:_____	☐ _____ x 150 mg tablets ☐ _____ x 500 mg tablets	

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: ____ / ____ / ____