

Oncology

Breast Cancer (drugs A-I)

(Afinitor®, Ibrance®)



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis (C00-D49): _____		Diagnosis date: _____	
Mutations: <input type="checkbox"/> HER2 <input type="checkbox"/> _____		ER: <input type="checkbox"/> Positive <input type="checkbox"/> Negative PR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Quantity	Refill
<input type="checkbox"/> Afinitor® (everolimus)	<input type="checkbox"/> Take 10 mg by mouth once daily with a full glass of water <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 10 mg tablets <input type="checkbox"/> _____
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. <input type="checkbox"/> _____	1120 mL <input type="checkbox"/> _____
<input type="checkbox"/> Ibrance® (palbociclib)	<input type="checkbox"/> Take 125 mg by mouth once daily with food on days 1-21 of a 28-day cycle <input type="checkbox"/> _____ Patient will be obtaining either Femara® or Faslodex® at: <input type="checkbox"/> Diplomat (fill prescription below) <input type="checkbox"/> Other pharmacy <input type="checkbox"/> Not receiving (Reason: _____)	<input type="checkbox"/> 21 x 125 mg capsules <input type="checkbox"/> _____
<input type="checkbox"/> Femara® (letrozole)	<input type="checkbox"/> Take 2.5 mg by mouth once daily Ibrance® and Femara® (letrozole) are automatically dispensed in a CarePak™. CarePak™ is a specially designed package with clear blister rows that holds a month's supply of oral medication(s), giving a patient an organized and convenient way to follow their medication schedule. <input type="checkbox"/> Check here to opt out of CarePak™	<input type="checkbox"/> 28 x 2.5 mg tablets _____
<input type="checkbox"/> Faslodex® (fulvestrant)	<input type="checkbox"/> Inject 250 mg (5 mL) intramuscularly slowly over 1-2 minutes into each buttock on days 1 and 15	<input type="checkbox"/> 4 PFS 0
	<input type="checkbox"/> Inject 250 mg (5 mL) intramuscularly slowly over 1-2 minutes into each buttock on day 29 and once monthly thereafter	<input type="checkbox"/> 2 PFS _____

Endocrine Therapy Options			
Medication	Directions	Quantity	Refill
Evista® (raloxifene) Fareston® (toremifene) Nolvadex® (tamoxifen)			
Arimidex® (anastrozole) Aromasin® (exemestane)			
<input type="checkbox"/> Femara® (letrozole)			
<input type="checkbox"/> Faslodex® (fulvestrant)			

§ Kisqali®, Nerlynx™, Tykerb® and Xeloda® are listed alphabetically on respective enrollment form.§

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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