

Oncology Breast Cancer (drugs U-Z)

(Verzenio™, Xeloda®)



Prescriber + Shipping Information

Patient name: _____ DOB: _____
 Sex: Female Male SSN: _____
 Language: _____ Wt: _____ kg lbs Ht: _____ cm in
 Address: _____
 Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate: _____
 Caregiver name: _____ Relation: _____
 Local pharmacy: _____ Phone: _____
 Insurance plan: _____ Plan ID: _____

Prescriber name: _____
 NPI: _____
 Address: _____
 Apt/Suite: _____ City: _____ State: _____ Zip: _____
 Contact: _____
 Phone: _____ Alternate: _____
 Fax: _____
 Email: _____
 If shipping to prescriber: First Fill Always 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: HER2 _____ ER: Positive Negative PR: Positive 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: NKDA Other: _____

Prescription

Quantity

Refill

§ Afinitor®, Ibrance®, Kisqali®, Lynparza®, Nerlynx™, Talzena™, and Tykerb® are listed alphabetically on respective enrollment forms. §

Verzenio™ (abemaciclib)	Take 150 mg by mouth twice daily Take 200 mg by mouth twice daily _____	56 x 150 mg tablets 56 x 200 mg tablets _____	_____
Faslodex® (fulvestrant)	Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on days 1 and 15	4 PFS	0
Faslodex® (fulvestrant)	Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on day 29 then once monthly thereafter	2 PFS	_____
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 _____	<input type="checkbox"/> _____ x 150 mg tablets <input type="checkbox"/> _____ x 500 mg tablets <input type="checkbox"/> _____	_____

Endocrine Therapy Options

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

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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