Oncology
Breast Cancer (drugs U-Z)
(Verzenio™, Xeloda®)

DIPLOMAT®

--Select One--
Phone
Fax
Insert Sales Contact Name (if known)

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

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

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 ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription

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

Prescription		Quantity	Refill
☐ **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/m²/dose x _____ m²) 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 ☐ _____	_____

Endocrine Therapy Options

Medication	Directions	Quantity	Refill
☐ Evista® (raloxifene) ☐ Fareston® (toremifene) ☐ Nolvadex® (tamoxifen)			
☐ Arimidex® (anastrozole) ☐ Aromasin® (exemestane) ☐ 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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