

Oncology

Breast Cancer



Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

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: NKDA Other: _____

Prescription	Quantity	Refill
<input type="checkbox"/> Afinitor® (everolimus)	<input type="checkbox"/> Take 10 mg once daily by mouth with a full glass of water <input type="checkbox"/> _____	<input type="checkbox"/> 28 x 10 mg tablets <input type="checkbox"/> _____
<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 once daily by mouth 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 once daily by mouth 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
	<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
<input type="checkbox"/> Tykerb® (lapatinib)	<input type="checkbox"/> Take 1,250 mg once daily by mouth at least one hour before or after a meal on days 1-21 of a 28-day cycle <input type="checkbox"/> Take 1,500 mg once daily by mouth at least one hour before or after a meal <input type="checkbox"/> _____	<input type="checkbox"/> 105 x 250 mg tablets <input type="checkbox"/> 180 x 250 mg tablets <input type="checkbox"/> _____
<input type="checkbox"/> Xeloda® (capecitabine)	Take _____ mg (1250 mg/m ² /dose x _____ m ²) twice daily (every 12 hours) by mouth within 30 minutes after a meal on days 1-14 of a 21-day cycle <input type="checkbox"/> _____	<input type="checkbox"/> _____ x 150 mg tablets <input type="checkbox"/> _____ x 500 mg tablets <input type="checkbox"/> _____

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

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

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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