Oncology
Breast Cancer

DIPLOMAT®

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

Patient 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 + Shipping Information

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		Quantity	Refill
☐ **Afinitor® (everolimus)**	☐ Take 10 mg once daily by mouth with a full glass of water ☐ _____	☐ 28 x 10 mg tablets ☐ _____	_____
☐ **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. ☐ _____	☐ 1120 mL ☐ _____	_____
☐ **Ibrance® (palbociclib)**	☐ Take 125 mg once daily by mouth with food on days 1-21 of a 28-day cycle ☐ _____	☐ 21 x 125 mg capsules ☐ _____	_____
	Patient will be obtaining either Femara® or Faslodex® at: ☐ Diplomat (fill prescription below) ☐ Other pharmacy ☐ Not receiving (Reason:_____)		
☐ **Femara® (letrozole)**	☐ 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.* ☐ **Check here to opt out of CarePak™**	☐ 28 x 2.5 mg tablets	_____
☐ **Faslodex® (fulvestrant)**	☐ Inject 250 mg (5 mL) intramuscularly slowly over 1-2 minutes into each buttock on days 1 and 15	☐ 4 PFS	0
	☐ Inject 250 mg (5 mL) intramuscularly slowly over 1-2 minutes into each buttock on day 29 and once monthly thereafter	☐ 2 PFS	_____
☐ **Tykerb® (lapatinib)**	☐ 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 ☐ Take 1,500 mg once daily by mouth at least one hour before or after a meal ☐ _____	☐ 105 x 250 mg tablets ☐ 180 x 250 mg tablets ☐ _____	_____
☐ **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 ☐ _____	☐ ____ 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: _____

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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