

Oncology Breast Cancer J-Z

(Kisqali®, Tykerb®, Xeloda®)



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
<i>§Afinitor® and Ibrance® are listed alphabetically on respective enrollment form.§</i>		
<input type="checkbox"/> Kisqali® (ribociclib) Femara® (letrozole) Co-pack	Take 600 mg of Kisqali® once daily by mouth on days 1-21 with 2.5 mg of Femara® by mouth once daily on days 1-28 of a 28-day cycle.	63 x 200 mg tablets of Kisqali® 28 x 2.5 mg tablets of Femara®
Kisqali® (ribociclib)	Take 600 mg once daily by mouth on days 1-21 of a 28-day cycle Patient will be obtaining an aromatase inhibitor at: Diplomat (fill prescription below) <input type="checkbox"/> Other pharmacy <input type="checkbox"/> Not receiving (Reason: _____)	63 x 200 mg tablets
Tykerb® (lapatinib)	Take 1,250 mg once daily by mouth at least one hour before or after a meal 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
Xeloda® (capecitabine)	Take _____ mg (_____ 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"/> _____ x 150 mg tablets <input type="checkbox"/> _____ x 500 mg tablets

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: _____

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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