Oncology
Breast Cancer (drugs J-Z)
(Kisqali®, Tykerb®, Xeloda®)

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

§Afinitor® and Ibrance® are listed alphabetically on respective enrollment form.§

Prescription	Directions	Quantity	Refill
❑ **Kisqali® (ribociclib) Femara® (letrozole) Co-pack**	Take 600 mg of Kisqali® by mouth once daily 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 by mouth once daily on days 1-21 of a 28-day cycle ____________ Patient will be obtaining an aromatase inhibitor at: Diplomat (fill prescription below) ❑ Other pharmacy ❑ Not receiving (Reason:____________)	63 x 200 mg tablets ____________	_____
Tykerb® (lapatinib)	Take 1,250 mg by mouth once daily at least one hour before or after a meal Take 1,500 mg by mouth once daily at least one hour before or after a meal ❑ ____________	❑ 105 x 250 mg tablets 180 x 250 mg tablets ____________	_____
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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