

# Oncology Breast Cancer (drugs U-Z)

(Verzenio™, Xeloda®)



## 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: \_\_\_\_\_

Prescriber name: \_\_\_\_\_  
 NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 If shipping to prescriber:  First Fill  Always  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:  HER2  \_\_\_\_\_ ER:  Positive  Negative PR:  Positive  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

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

<b>Verzenio™ (abemaciclib)</b>	Take 150 mg by mouth twice daily Take 200 mg by mouth twice daily _____	56 x 150 mg tablets 56 x 200 mg tablets	_____
<b>Faslodex® (fulvestrant)</b>	Inject 500 mg (250 mg/5 mL into each buttock) intramuscularly slowly over 1-2 minutes on days 1 and 15	4 PFS	0
<b>Faslodex® (fulvestrant)</b>	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	_____
<b>Xeloda® (capecitabine)</b>	Take _____ mg (_____ mg/m <sup>2</sup> /dose x _____ m <sup>2</sup> ) by mouth twice daily (every 12 hours) 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: \_\_\_\_\_

*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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