

For assistance, contact your pharmacy representative: \_\_\_\_\_ Phone: \_\_\_\_\_ (For providers only)

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital (may not be faxed by patient).

### Breast and Ovarian Cancers

#### Prescription/Pharmacy Intake Form

Pharmacy: \_\_\_\_\_  
Pharmacy Fax: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_  
Date Needed: \_\_\_\_\_ Ship To:  Prescriber's Office  Patient's Home  Other: \_\_\_\_\_

#### PATIENT INFORMATION

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Phone # (Daytime): \_\_\_\_\_ Phone # (Evening): \_\_\_\_\_  
Insurance provider (Please include copy of front and back of card): \_\_\_\_\_  
ID #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  Patient is eligible for Medicare

#### CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

Patient is new to therapy  Patient is currently on therapy Start date: \_\_\_\_\_  
ICD-10 code: \_\_\_\_\_ ICD-10 description: \_\_\_\_\_  
Weight: \_\_\_\_\_ lb  kg Date: \_\_\_\_\_ Height: \_\_\_\_\_ in  cm Date: \_\_\_\_\_ BSA: \_\_\_\_\_ m<sup>2</sup>  
Allergies: \_\_\_\_\_  
Please indicate the documents(s) attached:  Failed therapies  Recent laboratory results  Recent pathology report  Recent office notes  Copy of front and back of insurance card  
**Breast Cancer:**  Positive  Negative **Breast Cancer:**  Positive  Negative **Ovarian Cancer:**  Positive  Negative  
**BRCA mutation**  Positive  Negative **Estrogen Receptor Status**  Positive  Negative **BRCA mutation**  Positive  Negative  
**PIK2CA mutation**  Positive  Negative **HER2 Status**  Positive  Negative  
**Progesterone Receptor Status**  Positive  Negative

Is patient postmenopausal?  Yes  No

Medication	Dose/Directions/Frequency	Qty	Refills
<input type="checkbox"/> Afinitor† <input type="checkbox"/> Ibrance† <input type="checkbox"/> Kisqali†			
<input type="checkbox"/> Kisqali Femara Co-Pack <input type="checkbox"/> Lynparza capsules* <input type="checkbox"/> Lynparza tablets*			
<input type="checkbox"/> Piqray <input type="checkbox"/> Talzenna <input type="checkbox"/> Tykerb†			
<input type="checkbox"/> Verzenio† <input type="checkbox"/> Xeloda			
<input type="checkbox"/> Other: _____			
<b>†If prescribing Afinitor:</b> <input type="checkbox"/> Aromasin			
<b>†If prescribing Ibrance:</b> <input type="checkbox"/> Arimidex <input type="checkbox"/> Aromasin			
<b>†If prescribing Kisqali:</b> <input type="checkbox"/> Arimidex <input type="checkbox"/> Aromasin			
<b>†If prescribing Tykerb:</b> <input type="checkbox"/> Femara			
<b>†If prescribing Verzenio:</b> <input type="checkbox"/> Arimidex <input type="checkbox"/> Aromasin			
<input type="checkbox"/> MuGard <input type="checkbox"/> Other: _____			
<input type="checkbox"/> Akynzeo <input type="checkbox"/> Aloxi <input type="checkbox"/> Anzemet			
<input type="checkbox"/> Emend <input type="checkbox"/> Sancuso <input type="checkbox"/> Zofran			
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Granix <input type="checkbox"/> Leukine <input type="checkbox"/> Neupogen			
<input type="checkbox"/> Neulasta <input type="checkbox"/> Zarxio			
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Aranesp <input type="checkbox"/> Procrit			
<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Arixtra <input type="checkbox"/> Fragmin			
<input type="checkbox"/> Heparin <input type="checkbox"/> Lovenox			
<input type="checkbox"/> Other: _____			

\* Available at select health system pharmacy locations only.

#### PRESCRIBER INFORMATION

Prescriber's name: \_\_\_\_\_ Practice/facility: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Office contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_ Best time to call: \_\_\_\_\_ Preferred method of contact:  Email  Phone  Fax  
State license #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.