

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ ICD-10 Description: _____ Start Date: _____
 Weight: _____ lb kg Height: _____ in cm BSA: _____ m² Premenopause Postmenopause

Prior Failed Therapies:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Reason for Discontinuation: _____

Mutations:

- BRCA Mutation Positive Negative
 PIK2CA Mutation Positive Negative
 Disease characteristics:
 Advanced Metastatic Unresectable

- HER2 Status:** Positive Negative
Progesterone Receptor Status: Positive Negative
Estrogen Receptor (HR) Status: Positive Negative
Additional Therapies: Aromatase Inhibitor Fulvestrant
 Capecitabine Docetaxel Trastuzumab
Duration of treatment: 5 years 10 years
 Until Disease/Tumor Progression Other: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ARIMIDEX®	<input type="checkbox"/> 1mg tablets	<input type="checkbox"/> Take 1mg by mouth once daily		
<input type="checkbox"/> AROMASIN®	<input type="checkbox"/> 25mg tablets	<input type="checkbox"/> Take 25mg by mouth once daily		
<input type="checkbox"/> EVISTA®	<input type="checkbox"/> 60mg tablets	<input type="checkbox"/> Take 60mg by mouth once daily		
<input type="checkbox"/> FARESTON®	<input type="checkbox"/> 60mg tablets	<input type="checkbox"/> Take 60mg by mouth once daily		
<input type="checkbox"/> FEMARA®	<input type="checkbox"/> 2.5mg tablets	<input type="checkbox"/> Take 2.5mg by mouth once daily		
<input type="checkbox"/> KISQALI FEMARA CO-PACK®	<input type="checkbox"/> 200mg daily dose: Kisqali® 200mg and Femara® 2.5mg <input type="checkbox"/> 400mg daily dose: Kisqali® 200mg and Femara® 2.5mg <input type="checkbox"/> 600mg daily dose: Kisqali® 200mg and Femara® 2.5mg	<input type="checkbox"/> Recommended starting dose: Take 600 mg by mouth of Kisqali® once daily for 21 consecutive days followed by 7 days off Kisqali® treatment along with Femara 2.5mg tablet once daily for 28 days <input type="checkbox"/> First reduction: Take 400mg by mouth of Kisqali® once daily for 21 consecutive days followed by 7 days off Kisqali® treatment along with Femara® 2.5mg tablet once daily for 28 days <input type="checkbox"/> Second reduction: Take 200 mg by mouth of Kisqali® once daily for 21 consecutive days followed by 7 days off Kisqali® treatment along with Femara® 2.5mg tablet once daily for 28 days		
<input type="checkbox"/> KISQALI THERAPY PACK®	<input type="checkbox"/> 200mg dose: 200mg (21 ea) tablets <input type="checkbox"/> 400mg dose: 200mg (14 ea, 42 ea) tablets <input type="checkbox"/> 600mg dose: 200mg (21 ea, 63 ea) tablets	<input type="checkbox"/> Take 600 mg by mouth once daily for 21 days followed by 7 days off in combination with an aromatase inhibitor or fulvestrant		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.

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<input type="checkbox"/> PIQRAY THERAPY PACK®	<input type="checkbox"/> 200mg daily dose: 200mg (28 ea) tablets <input type="checkbox"/> 250mg daily dose: 200mg tablets and 50mg tablets (28 ea) <input type="checkbox"/> 300mg daily dose: 2 x 150mg (28 ea)	<input type="checkbox"/> Take 300mg by mouth once daily in combination with fulvestrant		
<input type="checkbox"/> SOLTAMOX®	<input type="checkbox"/> 10mg/5ml oral solution	<input type="checkbox"/> Take 20mg by mouth once daily <input type="checkbox"/> Take 40mg by mouth once daily		
<input type="checkbox"/> TAMOXIFIN®	<input type="checkbox"/> 10mg tablets <input type="checkbox"/> 20mg tablets	<input type="checkbox"/> Take 20mg by mouth once daily <input type="checkbox"/> Take 40mg by mouth once daily		
<input type="checkbox"/> TALZENNA®	<input type="checkbox"/> 0.25mg tablets <input type="checkbox"/> 1mg tablets	<input type="checkbox"/> Take 1mg by mouth once daily		
<input type="checkbox"/> TUKYSA®	<input type="checkbox"/> 50mg tablets <input type="checkbox"/> 150mg tablets	<input type="checkbox"/> Take 300mg by mouth twice daily in combination with trastuzumab and capecitabine		
<input type="checkbox"/> TYKERB®	<input type="checkbox"/> 250 mg tablets	<input type="checkbox"/> Take 1,250 mg by mouth once daily in combination with capecitabine <input type="checkbox"/> Take 1,500 mg by mouth once daily in combination with letrozole		
<input type="checkbox"/> XELODA®	<input type="checkbox"/> 150mg tablets <input type="checkbox"/> 500mg tablets	<input type="checkbox"/> Take 1,250 mg/m ² by mouth twice daily for 2 weeks followed by 1 week off, every 21 days		
<input type="checkbox"/> OTHER	_____	_____		

Supportive Medications	Dosage & Direction	QTY	Refills
<input type="checkbox"/> Budesonide 9mg <input type="checkbox"/> Colestipol 2g <input type="checkbox"/> Decadron® <input type="checkbox"/> Emend® <input type="checkbox"/> Loperamide 4mg <input type="checkbox"/> Lovenox®	<input type="checkbox"/> Neulasta® <input type="checkbox"/> Neupogen® <input type="checkbox"/> Procrit® <input type="checkbox"/> Zofran® 4mg		

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Signature: _____ Date: _____ Signature: _____ Date: _____

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