Ochsner Specialty Pharmacy

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Oncology
Breast Cancer

Patient 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: _____ Date: _____
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		Quantity	Refill
☐ **Afinitor® (everolimus)**	☐ Take 10 mg once daily by mouth with a full glass of water ☐ _____	☐ 28 x 10 mg tablets ☐ _____	_____
☐ **Afinitor® Disperz (everolimus)**	☐ Take 10 mg once daily by mouth per prescriber direction ☐ _____	☐ 56 x 5 mg tablets ☐ _____	_____
☐ **Faslodex® (fulvestrant)**	☐ Inject 500 mg intramuscularly slowly over 1-2 minutes into each buttock on days 1 and 15, 29 and once monthly in the provider office	☐4 PFS	0
	☐ Inject 250 mg (5 mL) intramuscularly slowly over 1-2 minutes into each buttock on days 1, 15, and 29 and once monthly thereafter in the provider office	☐ 2 PFS	_____
☐ **Tykerb® (lapatinib)**	☐ Take 1,250 mg once daily by mouth at least one hour before or after a meal on days 1-21 of a 28-day cycle ☐ Take 1,500 mg once daily by mouth at least one hour before or after a meal ☐ _____	☐ 105 x 250 mg tablets ☐ 180 x 250 mg tablets ☐ _____	_____
☐ **Xeloda® (capecitabine)**	☐ Take _____ mg (1250 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 ☐ _____	☐ ____ 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)			

By signing this form and using our services, you are authorizing Ochsner Speicalty Pharmacy to serve as your prior authorization designated agent in dealing with prescrption and medical insurance companies. Prescriber Signature Below: (Physician attests that this is his/her legal signature **NO STAMPS)**

_____ _____
Prescriber's signature Substitution Allowed Prescriber's Signature Dispense as Written