BREAST CANCER CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

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:_____ m^2 ❑ Premenopause ❑ Postmenopause

Prior Failed Therapies:

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

Reason for Discontinuation:

Mutations:

BRCA Mutation ❑ Positive ❑ Negative
PIK2CA Mutation ❑ Positive ❑ Negative

Disease characterisitcs:

❑ Advanced ❑ Metatstic ❑ Unresectable

HER2 Status: ❑ Positive ❑ Negative
Progesterone Receptor Status: ❑ Positive ❑ Negative
Estrogen Receptor (HR) Status: ❑ Positive ❑ Negative
Additonal 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 PRODUCT DELIVERY: ❍ Patient's Home ❍ 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
❑ ARIMIDEX®	❑ 1mg tablets	❑ Take 1mg by mouth once daily		
❑ AROMASIN®	❑ 25mg tablets	❑ Take 25mg by mouth once daily		
❑ EVISTA®	❑ 60mg tablets	❑ Take 60mg by mouth once daily		
❑ FARESTON®	❑ 60mg tablets	❑ Take 60mg by mouth once daily		
❑ FEMARA®	❑ 2.5mg tablets	❑ Take 2.5mg by mouth once daily		
❑ KISQALI FEMARA CO-PACK®	❑ 200mg daily dose: Kisqali® 200mg and Femara® 2.5mg ❑ 400mg daily dose: Kisqali® 200mg and Femara® 2.5mg ❑ 600mg daily dose: Kisqali® 200mg and Femara® 2.5mg	❑ **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 ❑ **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 ❑ **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		
❑ KISQALI THERAPY PACK®	❑ 200mg dose: 200mg (21 ea) tablets ❑ 400mg dose: 200mg (14 ea, 42 ea) tablets ❑ 600mg dose: 200mg (21 ea, 63 ea) tablets	❑ 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.

BELL Rexall PHARMACY

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PRESCRIPTION INFORMATION:

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

Medication	Dosage & Strength	Direction	QTY	Refills
❑ PIQRAY THERAPY PACK®	❑ 200mg daily dose: 200mg (28 ea) tablets ❑ 250mg daily dose: 200mg tablets and 50mg tablets (28 ea) ❑ 300mg daily dose: 2 x 150mg (28 ea)	❑ Take 300mg by mouth once daily in combination with fulvestrant		
❑ SOLTAMOX®	❑ 10mg/5ml oral solution	❑ Take 20mg by mouth once daily ❑ Take 40mg by mouth once daily		
❑ TAMOXIFIN®	❑ 10mg tablets ❑ 20mg tablets	❑ Take 20mg by mouth once daily ❑ Take 40mg by mouth once daily		
❑ TALZENNA®	❑ 0.25mg tablets ❑ 1mg tablets	❑ Take 1mg by mouth once daily		
❑ TUKYSA®	❑ 50mg tablets ❑ 150mg tablets	❑ Take 300mg by mouth twice daily in combination with trastuzumab and capecitabine		
❑ TYKERB®	❑ 250 mg tablets	❑ Take 1,250 mg by mouth once daily in combination with capecitabine ❑ Take 1,500 mg by mouth once daily in combination with letrozole		
❑ XELODA®	❑ 150mg tablets ❑ 500mg tablets	❑ Take 1,250 mg/m^2 by mouth twice daily for 2 weeks followed by 1 week off, every 21 days		
❑ OTHER	_____	_____		

Supportive Medications		Dosage & Direction	QTY	Refills
❑ Budesonide 9mg ❑ Colestipol 2g ❑ Decadron® ❑ Emend® ❑ Loperamide 4mg ❑ Lovenox®	❑ Neulasta® ❑ Neupogen® ❑ Procrit® ❑ Zofran® 4mg			

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: _____

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