



SPECIALTY PHARMACY

BREAST CANCER ORAL

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES & LABS MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: Breast Cancer Other: _____ Diagnosis Code: _____ Secondary Diagnosis: _____ Diagnosis Code: _____
 Weight: _____ kg lb Height: _____ cm in BSA: _____ m² Metastatic Disease: Yes No HER2: Positive Negative
 Hormone Receptor: ER Positive ER Negative PR Positive PR Negative Treatment Status: New to Therapy Continuation of Therapy, Start Date: ___/___/___
 Prior Therapy: _____ Length of Treatment: _____ Discontinuation Reason: _____
 Allergies: NKDA Other: _____

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Afinitor [®]	<input type="checkbox"/> 2.5mg tablet <input type="checkbox"/> 5mg tablet <input type="checkbox"/> 7.5mg tablet <input type="checkbox"/> 10mg tablet	Take 1 tablet by mouth once daily.	28 tablets	_____
<input type="checkbox"/> Cyclophosphamide	<input type="checkbox"/> 25mg capsule <input type="checkbox"/> 50mg capsule		_____	_____
<input type="checkbox"/> Ibrance [®] <small>*Prescribe aromatase inhibitor or fulvestrant below, as needed.</small>	<input type="checkbox"/> 75mg capsule <input type="checkbox"/> 100mg capsule <input type="checkbox"/> 125mg capsule	Take 1 capsule by mouth daily for 21 days, followed by 7 days off; repeat every 28 days.	21 capsules	_____
<input type="checkbox"/> Kisqali [®] <small>*Prescribe aromatase inhibitor or fulvestrant below, as needed.</small>	<input type="checkbox"/> 200mg dose pack <input type="checkbox"/> 400mg dose pack <input type="checkbox"/> 600mg dose pack <input type="checkbox"/> Kisqali and Femara 2.5mg dose pack	Take 1 tablet by mouth daily for 21 days on then 7 days off, as directed on package. Take 2 tablets by mouth daily for 21 days on then 7 days off, as directed on package. Take 3 tablets by mouth daily for 21 days on then 7 days off, as directed on package. Take Kisqali _____ mg by mouth daily for 21 days, then take 7 days off, and take 1 Femara tablet by mouth daily for 28 days as directed on package.	1 pack	_____
<input type="checkbox"/> Talzenna [™]	<input type="checkbox"/> 0.25mg capsule <input type="checkbox"/> 1mg capsule	Take 1 capsule by mouth daily.	30 capsules	_____
<input type="checkbox"/> Tykerb [®]	250mg tablet	Take _____ mg by mouth daily.	30-day supply	_____
<input type="checkbox"/> Xeloda [®]	<input type="checkbox"/> 150mg tablet <input type="checkbox"/> 500mg tablet	<input type="checkbox"/> Take _____ mg by mouth every 12 hours for 14 days on, then 7 days off. <input type="checkbox"/> Conjunction with radiation: Take _____ mg by mouth every 12 hours with radiation for _____ days a week. For a total of _____ weeks. <input type="checkbox"/> Other: _____	21-day cycle _____ _____	_____
Supportive therapies <input type="checkbox"/> Arimidex [®] <input type="checkbox"/> Aromasin [®] <input type="checkbox"/> Femara [®] <input type="checkbox"/> Faslodex [®]	1mg tablet 25mg tablet 2.5mg tablet 250mg/5ml syringe	Take 1 tablet by mouth daily. Take 1 tablet by mouth daily. Take 1 tablet by mouth daily. <input type="checkbox"/> Loading Dose: Inject 500mg (2 syringes) intramuscularly on days 1, 15, and 29, and once monthly thereafter. <input type="checkbox"/> Maintenance Dose: Inject 500mg (2 syringes) intramuscularly every 28 days.	28 tablets 28 tablets 28 tablets 6 syringes 2 syringes	_____
<input type="checkbox"/> Other:	_____	_____	_____	_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy[™] and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (stamps not allowed) Substitution Allowed _____ Date _____ Prescriber's Signature (stamps not allowed) Dispense As Written _____ Date _____

The prescriber is to comply with his/her state-specific requirements such as e-prescribing, state-specific prescription form, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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