For assistance, contact your pharmacy representative: ______________________ Phone:______________________ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.
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

☐Central Pharmacy: ______________________
☐Retail/Community 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: __________ m²
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:
BRCA mutation ☐Positive ☐Negative
Estrogen Receptor Status ☐Positive ☐Negative
HER2 Status ☐Positive ☐Negative
Progesterone Receptor Status ☐Positive ☐Negative

Ovarian Cancer:
BRCA mutation ☐Positive ☐Negative
Is patient postmenopausal? ☐Yes ☐No

Medication	Dose/Directions/Frequency	Qty	Refills
☐Afinitor ☐Ibrance ☐Kisqali ☐Kisqali Femara Co-Pack ☐Lynparza capsules* ☐Lynparza tablets* ☐Talzenna ☐Tykerb ☐Verzenio ☐Xeloda ☐Other: __________			
If prescribing:			
Afinitor ☐Aromasin			
Ibrance ☐Arimidex ☐Aromasin ☐Femara			
Kisqali ☐Arimidex ☐Aromasin ☐Femara			
Tykerb ☐Femara ☐Xeloda			
Verzenio ☐Arimidex ☐Aromasin ☐Femara			
☐Akynzeo ☐Aloxi ☐Anzemet ☐Emend ☐Sancuso ☐Zofran ☐Other: __________			
☐Granix ☐Leukine ☐Neupogen ☐Neulasta ☐Zarxio ☐Other: __________			
☐Aranesp ☐Procrit ☐Other: __________			
☐Arixtra ☐Fragmin ☐Heparin ☐Lovenox ☐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.
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