Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

BREAST CANCER REFERRAL FORM

PATIENT INFORMATION						
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.	
SSN:	Phone:	Allergies:				
Address:		City:	State:	Zip:		
Emergency Contact:	Phone:		❑**Please attach demographic information**			

PRESCRIBER INFORMATION					
Prescriber:	NPI:	DEA:	State Lic:		
Supervising Physician:		Practice Name:			
Address:		City:	State:	Zip:	
Phone:	Fax:	Key Office Contact:	Phone:		

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Diagnosis: ❑_____ Breast cancer ❑Other_____

- Has patient been treated previously for this condition? ❑Yes ❑No (If pt has been on Xeloda, please indicate dose and duration of therapy)
  Medications:_____
- Is patient currently on therapy? ❑Yes ❑No Medications: _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes, what is the washout period?
  _____

Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____
_____

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

❑**Afinitor**	❑**Arimidex**	❑**Aromasin**	❑**Avastin**
❑**Capecitabine**	❑**Cyclophosphamide**	❑**Femara**	❑**Halaven**
❑**Herceptin**	❑**Ibrance**	❑**Kadcyla**	❑**Nerlynx**
❑**Perjeta**	❑**Tamoxifen**	❑**Tykerb**	❑**Other:**_____

Drug: _____ Strength: _____ Dosage: _____ Qty: ____ Refills: ___
Drug: _____ Strength: _____ Dosage: _____ Qty: ____ Refills: ___
Drug: _____ Strength: _____ Dosage: _____ Qty: ____ Refills: ___
Drug: _____ Strength: _____ Dosage: _____ Qty: ____ Refills: ___

❑**Antimetics: ❑Chemo-induced N/V ❑Radiation-induced N/V**
❑Aloxi ❑Emend ❑Dolasetron ❑Granisetron ❑Ondansetron ❑Prochlorperazine ❑Other:_____
Dosage: _____ Qty: ____ Refills: ___

❑**Supportive Agents:**
❑Aranesp ❑Epogen ❑Granix ❑Loperamide ❑Neupogen ❑Neulasta ❑Procrit ❑Prothelial ❑Zarxio ❑Other:_____
Dosage: _____ Qty: ____ Refills: ___

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

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