



2100 New Bern Ave,  
Raleigh, NC 27610

P. 855-326-9112 / F. 855-326-9114

**Oncology—Breast Cancer**

Prescriber information	
Prescriber:	NPI:
Supervising physician:	NPI:
Address:	
Phone:	Fax:
Office contact:	

Patient information			
Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB:	SSN:
Address:	City:	State:	Zip:
Phone:	Emergency contact:	Phone:	
Weight:	Height:	Allergies:	
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		Needs interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Please include copies of the patient's insurance card or local pharmacy information.**

Medical information		
Primary diagnosis:	ICD-10:	Date of diagnosis:
Mutations: HER2: <input type="checkbox"/> Positive <input type="checkbox"/> Negative ER: <input type="checkbox"/> Positive <input type="checkbox"/> Negative PIK3CA: <input type="checkbox"/> Positive <input type="checkbox"/> Negative PR: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		
Previous therapies:	Duration:	Outcome:

Prescription information				
Drug	Strength	Directions	Qty	Refills
<input type="checkbox"/> Piqray®		<input type="checkbox"/> Take 300 mg (two 150 mg tablets) by mouth once daily with food. <input type="checkbox"/> Take 250 mg (one 200 mg tablet & one 50 mg tablet) by mouth once daily with food. <input type="checkbox"/> Take 200 mg (one 200 mg tablet) by mouth once daily with food.	<input type="checkbox"/> 28 day supply	
<input type="checkbox"/> Faslodex®	250 mg/5 ml PFS	<input type="checkbox"/> Inject one syringe (250 mg) into each buttock intramuscularly slowly over 1 to 2 minutes on days 1 and 15. <input type="checkbox"/> Inject one syringe (250 mg) into each buttock intramuscularly slowly over 1 to 2 minutes on day 29 then once monthly thereafter.	<input type="checkbox"/> 4 PFS	
<input type="checkbox"/> Tykerb®	250 mg tablets	<input type="checkbox"/> Take five tablets (1,250 mg) by mouth once daily at least one hour before or after a meal. <input type="checkbox"/> Take six tablets (1,500 mg) by mouth once daily at least one hour before or after a meal.	<input type="checkbox"/> 105 tablets <input type="checkbox"/> 180 tablets	
<input type="checkbox"/> Xeloda®		<input type="checkbox"/> Take ____ mg (____ mg/m <sup>2</sup> /dose x ____ m <sup>2</sup> ) by mouth twice daily within 30 minutes after a meal on days 1 through 14 of a 21-day cycle.	<input type="checkbox"/> ____ x 150 mg tablets <input type="checkbox"/> ____ x 500 mg tablets	
<input type="checkbox"/> Femara®		<input type="checkbox"/> Take 2.5 mg by mouth once daily.	<input type="checkbox"/> 30 tablets	
<input type="checkbox"/> Xeloda®		<input type="checkbox"/> Take ____ mg (____ mg/m <sup>2</sup> /dose x ____ m <sup>2</sup> ) by mouth twice daily within 30 minutes after a meal on days 1 through 14 of a 21-day cycle.	<input type="checkbox"/> ____ x 150 mg tablets <input type="checkbox"/> ____ x 500 mg tablets	
<input type="checkbox"/> Other:			<input type="checkbox"/> 28 day supply	

Endocrine Therapy Options	Directions	Qty	Refills
<b>SERMs</b> <input type="checkbox"/> Raloxifene <input type="checkbox"/> Toremifene <input type="checkbox"/> Tamoxifen			
<b>Aromatase inhibitors</b> <input type="checkbox"/> Anastrozole <input type="checkbox"/> Exemestane <input type="checkbox"/> Letrozole			
<b>SERDs</b> <input type="checkbox"/> Faslodex®			
<input type="checkbox"/> Other:			

By signing below I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies.

**Stamp signature not allowed, physician attests this is his/her legal signature.**

**PHYSICIAN SIGNATURE REQUIRED**

**Dispense as Written / Brand Medically Necessary**

**Substitution allowed**

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