JOSEFS PHARMACY
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: ☐ M ☐ F DOB: SSN:

Address: City: State: Zip:

Phone: Emergency contact: Phone:

Weight: Height: Allergies:

Primary language: ☐ English ☐ Spanish ☐ Other: Needs interpreter: ☐ Yes ☐ 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*: ☐ Positive ☐ Negative *ER*: ☐ Positive ☐ Negative *PIK3CA*: ☐ Positive ☐ Negative *PR*: ☐ Positive ☐ Negative

Previous therapies:	Duration:	Outcome:

Prescription information

Drug	Strength	Directions	Qty	Refills
☐ Piqray®		☐ Take 300 mg (two 150 mg tablets) by mouth once daily with food. ☐ Take 250 mg (one 200 mg tablet & one 50 mg tablet) by mouth once daily with food. ☐ Take 200 mg (one 200 mg tablet) by mouth once daily with food.	☐ 28 day supply	
☐ Faslodex®	250 mg/5 ml PFS	☐ Inject one syringe (250 mg) into each buttock intramuscularly slowly over 1 to 2 minutes on days 1 and 15.	☐ 4 PFS	
		☐ Inject one syringe (250 mg) into each buttock intramuscularly slowly over 1 to 2 minutes on day 29 then once monthly thereafter.	☐ 2 PFS	
☐ Tykerb®	250 mg tablets	☐ Take five tablets (1,250 mg) by mouth once daily at least one hour before or after a meal.	☐ 105 tablets	
		☐ Take six tablets (1,500 mg) by mouth once daily at least one hour before or after a meal.	☐ 180 tablets	
☐ *Xeloda®*		☐ *Take _____ mg (_____ mg/m²/dose x _____ m²) by mouth twice daily within 30 minutes after a meal on days 1 through 14 of a 21-day cycle.*	☐ ____ x 150 mg tablets ☐ ____ x 500 mg tablets	
☐ *Femara®*		☐ *Take 2.5 mg by mouth once daily.*	☐ 30 tablets	
☐ Xeloda®		☐ Take _____ mg (_____ mg/m²/dose x _____ m²) by mouth twice daily within 30 minutes after a meal on days 1 through 14 of a 21-day cycle. ☐ _____	☐ ____ x 150 mg tablets ☐ ____ x 500 mg tablets	
☐ Other: _____		_____	☐ 28 day supply	

Endocrine Therapy Options	Directions	Qty	Refills
SERMs ☐ Raloxifene ☐ Toremifene ☐ Tamoxifen			
Aromatase inhibitors ☐ Anastrozole ☐ Exemestane ☐ Letrozole			
SERDs ☐ Faslodex®			
☐ 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**