Zarina Pharmacy
SPECIALTY & INFUSION

Breast Cancer Oral

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis: ☐ Breast Cancer ☐ Other: Dx Code: _____ Condition: _____ ☐ Secondary Diagnosis: Dx Code: _____ Condition: _____			BSA m2
Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Metastatic Disease: ☐ No ☐ Yes	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	Reason for Discontinuing
Allergies: ☐ NKDA ☐ Other: _____			Status: ☐ New ☐ Restart ☐ Continuing

Prescription Information

			Qty	Refills
☐ Afinitor®	☐ 2.5 mg Tablet ☐ 5 mg Tablet ☐ 7.5 mg Tablet ☐ 10 mg Tablet	Take 1 tablet by mouth once daily	28 Tablets	_____
☐ Cyclophosphamide	☐ 25 mg Capsule ☐ 50 mg Capsule		_____	_____
☐ Ibrance® *Prescribe aromatase inhibitor or Faslodex® below, as needed	☐ 75 mg Capsule ☐ 100 mg Capsule ☐ 125 mg Capsule	☐ Take 1 capsule by mouth once daily for 21 days, followed by 7 days off; repeat every 28 days	21	_____
	☐ 75 mg Tablet ☐ 100 mg Tablet ☐ 125 mg Tablet	☐ Take 1 tablet by mouth once daily for 21 days, followed by 7 days off; repeat every 28 days	21	_____
☐ Kisqali® *Prescribe aromatase inhibitor or Faslodex® below, as needed	☐ 200 mg Dose Pack ☐ 400 mg Dose Pack ☐ 600 mg Dose Pack ☐ Kisqali and Femara 2.5 mg Dose Pack	Take 1 tablet by mouth once daily for 21 days on then 7 days off, as directed on package Take 2 tablets by mouth once daily for 21 days on then 7 days off, as directed on package Take 3 tablets by mouth once daily for 21 days on then 7 days off, as directed on package Take Kisqali _____ mg by mouth once 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	_____
☐ Piqray® *Prescribe Faslodex® below, as needed	☐ 200 mg Dose Pack ☐ 250 mg Dose Pack ☐ 300 mg Dose Pack	Take one 200 mg tablet by mouth once daily Take one 200 mg tablet and one 50 mg tablet by mouth once daily Take two 150 mg tablets by mouth once daily	1 Pack	_____
☐ Talzenna®	☐ 0.25 mg Capsule ☐ 1 mg Capsule	Take 1 capsule by mouth once daily	30 Capsules	_____
☐ Tykerb®	250 mg Tablet	Take _____mg by mouth once daily on an empty stomach	30-Day Supply	_____
☐ Xeloda®	☐ 150 mg Tablet ☐ 500 mg Tablet	☐ Take _____ mg by mouth every 12 hours for 14 days on, then 7 days off ☐ Conjunction with radiation: Take _____ mg by mouth every 12 hours with radiation for _____ days a week for a total of _____ weeks ☐ Other: _____	21-Day Cycle _____ _____	_____
Supportive Therapies ☐ Arimidex® ☐ Aromasin® ☐ Femara® ☐ Faslodex®	1 mg Tablet 25 mg Tablet 2.5 mg Tablet 250 mg/5 mL Syringe	Take 1 tablet by mouth once daily Take 1 tablet by mouth once daily Take 1 tablet by mouth once daily ☐ Loading Dose: Inject 500 mg (2 syringes) intramuscularly on Day 1, Day 15 & Day 29, and once monthly thereafter ☐ Maintenance Dose: Inject 500 mg (2 syringes) intramuscularly every 28 days starting on Day 29	28 Tablets 28 Tablets 28 Tablets 4 Syringes 2 Syringes	_____ None _____
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** **Date**

Prescriber's Signature (no stamps) **Dispense As Written** **Date**