RX BIOTECH SPECIALTY PHARMACY
an aureus company

P: 800.657.2212 • F: 888.601.0049
www.RxBiotech.com

Breast Cancer

Physician Information

Send updates to: ◯ Fax: _____ ◯ Email: _____ ◯ Text: _____

Prescriber Name:		◯MD ◯DO ◯NP ◯PA	NPI:
Office Contact:	Practice Name / Supervising MD:		
Address:	City:		
State:	Zip:	Phone:	Fax:

Patient Information | PLEASE SEND COPY OF INSURANCE CARD

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: ◯ M ◯ F	Weight:	Height:	Diabetic: ◯ Y ◯ N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? ◯ Y ◯ N		

Insurance Information

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES

ICD-10/Diagnosis Code:	Has patient been treated previously for this condition? ◯ Y ◯ N	Medications:	
Is patient currently on therapy? ◯ Y ◯ N	Medications:	HER2: ◯ Y ◯ N	HR: ◯ Y ◯ N
If yes, what is the washout period?	Other medications patient is currently taking including OTC mediations with dosage and direction (or fax medication profile:)		
TREATMENT ARRANGEMENTS:	Ship Meds: ◯ Home ◯ Doctor's Office	Start Date: / /	*Counseling and education provided by Aureus's Clinical Team

Prescription Information

Medication	Dose/Strength	Sig	Quantity	Refills
◯ **AFINITOR®**	◯ 10mg tablet daily ◯ 5mg tablet daily ◯ Other:	◯ Take 1 tablet po daily	28 Day Supply	
◯ **ANTIEMETICS®**	◯ Compazine ◯ Emend ◯ Zofran ◯ Sancuso TP ◯ Other: _____			
◯ **ARANESP®** ◯ PFS ◯ Vial	◯ 10mcg ◯ 150mcg ◯ 25mcg ◯ 200mcg ◯ 40mcg ◯ 300mcg ◯ 60mcg ◯ 500mcg ◯ 100mcg	◯ Inject _____ mcg SubQ once a week ◯ Inject 500mcg SubQ every 3 weeks	28 Day Supply	
◯ **ARIMIDEX®**	◯ 1mg tablet	◯ Take 1mg tablet po daily	30 Day Supply	
◯ **AROMASIN®**	◯ 25mg (1 tablet) ◯ 50mg (2 tablets)	◯ Take 1 tablet po daily after a meal (postmenopausal) ◯ Take 2 tablets po daily after a meal (only if pt is is on a potent CYP3A4 Inducer)	30 Day Supply	
◯ **CYTOXAN®**	◯ 25mg tablet ◯ 50mg tablet	◯ Take 1 to 5mg/kg/day _____ mg _____ of 25mg tab and/or _____of 50mg tab po daily (Available in 25mg tab & 50mg tab, a combination of both strengths will be dispensed based on patient's total daily dose unless otherwise indicated)	30 Day Supply	
◯ **FEMARA®**	◯ 2.5mg tablet	◯ Take 2.5mg po daily (for pestmenopausal)	30 Day Supply	
◯ **NEUMEGA®**	◯ 5mg vial		28 Day Supply	
◯ **NEUPOGEN®** ◯ PFS ◯ Vial	◯ 300mcg ◯ 480mcg ◯ Other: _____	◯ Inject _____ mcg SubQ _____ times a week	28 Day Supply	
◯ **TAMOXIFEN**	◯ 10mg tab ◯ 20mg tab		30 Day Supply	
◯ **TYKERB®**	◯ 250mg tab	◯ Take 1250mg (5 tablets) po daily continuously on Days 1-21 in combination with **Xeloda®** one hour before or one hour after a meal ◯ Take 1500mg (6 tablets) po daily in combination with **Femara®** one hour before or one hour after a meal ◯ Other:	21 Day Cycle	
◯ **XELODA®**	◯ Dosage: _____ Xeloda is available in 500mg and 150mg tablets. A combination of both strengths will be dispensed based on patient's total daily dose unless otherwise indicated.	◯ Take 1250mg/m2 po BID for 14 days followed by 7 days of rest (2 weeks on 1 week off) Please indicate number of tablets to be taken at each dose: ◯ Take _____ of 500mg & _____ of 150mg tabs every AM & _____ of 500mg & _____ of 150mg tabs every PM for _____ days followed by _____ days of rest. ◯ Other:	QS for Dose	

By signing this form and utilizing our services, you are authorizing Aureus and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date

Substitution Permitted

Physician Signature:	Date

Dispense as Written