Publix Specialty Pharmacy #3213

ORAL ONCOLOGY: BREAST CANCER (FORM A)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ________________________ Patient's Last Name: ________________________

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:________________________

Address: ________________________ City: ______________ State: ___________ Zip: ____________

Primary Phone Number: (_____) ____________________ Alt. Phone Number: (_____) ____________________

Clinical Information: [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: _______________ Diagnosis: ☐ Breast Cancer ☐ Other: ____________________ HER2: ☐ Positive ☐ Negative

Treatment status: New to therapy Continuation of therapy, start date: ______/______/_________

Hormone receptor: ER positive PR positive Advanced/ metastatic disease: Yes No Weight: ______ kg lb,

ER negative PR negative Height: ______ cm in

Prior therapies, treatment dates, and reason for discontinuation: ________________________________

Other pertinent past medical history and/or drug therapy: ________________________________

Allergies: NKDA Other: ________________________________

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Afinitor (everolimus)	☐ 10 mg tablet ☐ 7.5 mg tablet ☐ 5 mg tablet ☐ 2.5 mg tablet	☐ Take 1 tab PO one time daily with a full glass of water ☐ Other: ________________________	☐ 28 days ☐ 84 days	______
☐ Kisqali (ribociclib)	200 mg tablet	☐ Take 600 mg (3 tabs) PO one time daily for 21 days on, then 7 days off ☐ Take 400 mg (2 tabs) PO one time daily for 21 days on, then 7 days off ☐ Take 200 mg (1 tab) PO one time daily for 21 days on, then 7 days off ☐ Other: ________________________	☐ 28 days ☐ 84 days	_______
☐ Piqray (alpelisib)	☐ 300 mg dose	Take 300 mg (2 x 150 mg tabs) PO one time daily with food	☐ 28 days ☐ 84 days	_______
	☐ 250 mg dose	Take 250 mg (1 x 200 mg tab and 1 x 50 mg tab) PO one time daily with food		
	☐ 200 mg dose	Take 200 mg (1 tab) PO one time daily with food		
☐ ____________	____________	________________________________	_______	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ________________________ DEA# ____________________ NPI # ________________________

Supervising Physician: ☐ Not Applicable ☐ ________________________ Supervising Physician NPI # ____________________

Address: ________________________ City: ______________ State: ___________ Zip: ____________

Office Phone Number: (_____) ______________ Fax Number: (_____) ______________ Office Contact: ____________________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

____________________________ ☐ Substitution allowed Date

____________________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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Publix Specialty Pharmacy #3213

ORAL ONCOLOGY: BREAST CANCER (FORM B)

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________ Patient's Last Name: ______________________

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name:______________________

Address: ______________________ City: ______________ State: ___________ Zip: ____________

Primary Phone Number: (_____) ______________________ Alt. Phone Number: (_____) ______________________

Clinical Information: [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: _______________ Diagnosis: ☐ Breast Cancer ☐ Other: ____________________ HER2: ☐ Positive ☐ Negative

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/_________

Hormone receptor: ☐ ER positive ☐ PR positive Advanced/ metastatic disease: ☐ Yes ☐ No Weight: ______☐ kg ☐ lb,

☐ ER negative ☐ PR negative Height: ______☐ cm ☐ in

Prior therapies, treatment dates, and reason for discontinuation: ______________________

Other pertinent past medical history and/or drug therapy: ______________________

Allergies: ☐ NKDA ☐ Other: ______________________

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Tykerb (lapatinib)	250 mg tablet	☐ Take 1,500 mg (6 tabs) PO one time daily at least 1 hour before or after food	30 days	_______
		☐ Take 1,250 mg (5 tabs) PO one time daily at least 1 hour before or after food	21 days	_______
		☐ Other: ______________________	______	_______
☐ Xeloda (capecitabine) Patient's BSA: ________ m^2	☐ 500 mg tablet ☐ 150 mg tablet	☐ Take ______ mg PO within 30 minutes after a meal every 12 hours for 14 days on, then 7 days off ☐ Other: ______________________	☐ 21 days _______	_______
☐ ____________	____________	______________________	_______	_______
☐ ____________	____________	______________________	_______	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ______________________ DEA# ____________________ NPI # ______________________

Supervising Physician: ☐ Not Applicable ☐ ______________________ Supervising Physician NPI # ______________________

Address: ______________________ City: ______________ State: ___________ Zip: ____________

Office Phone Number: (_____) ________________ Fax Number: (_____) __________________ Office Contact: ____________________

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Prescriber's signature: (stamps not accepted) ______________________ ☐ Substitution allowed Date ______________________ ☐ Dispense as written/ Do not substitute Date

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