PUBLIX PHARMACY

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Oral Oncology Referral Form: Breast Cancer

Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
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

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Caregiver name: _____

Clinical Information [Attach copy of labs and office notes]

Diagnosis code: _____ Diagnosis: ☐ Breast Cancer ☐ Other: _____ HER2: ☐ Positive ☐ Negative

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ___/___/_____ Hormone receptor: ☐ ER positive ☐ ER negative

Advanced/ metastatic disease: ☐ Yes ☐ No Weight: _____☐ kg ☐ lb, Height: _____☐ cm ☐ in ☐ PR positive ☐ PR negative

Prior therapies, reason for discontinuation, treatment dates: _____

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

Allergies: ☐ NKDA ☐ Other: _____

MEDICATION	DOSE/ STRENGTH	DIRECTIONS	DISPENSE QTY FOR	REFILLS
☐ Afinitor (everolimus)	☐ 10 mg tablet ☐ 7.5 mg tablet ☐ 5 mg tablet ☐ 2.5 mg tablet	☐ Take 1 tab PO once daily with a full glass of water ☐ Other: _____	☐ 28 days ☐ _____	_____
☐ Kisqali (ribociclib)	200 mg tablet	☐ Take 600 mg (3 tabs) PO once daily with or without food for 21 days on, then 7 days off ☐ Take 400 mg (2 tabs) PO once daily with or without food for 21 days on, then 7 days off ☐ Take 200 mg (1 tab) PO once daily with or without food for 21 days on, then 7 days off ☐ Other: _____	☐ 28 day cycle ☐ _____	_____
☐ Tykerb (lapatinib)	250 mg tablet	☐ Take 1,500 mg (6 tabs) PO once daily at least 1 hour before or after food	25 days	_____
		☐ Take 1,250 mg (5 tabs) PO once daily at least 1 hour before or after food	30 days	_____
		☐ Other: _____	_____	_____
☐ Xeloda (capecitabine) Patient's BSA: _____ m^2	☐ 500 mg tablet ☐ 150 mg tablet	☐ Take _____ mg PO every 12 hours with food for 14 days on, then 7 days off ☐ Other: _____	☐ 21 day cycle ☐ _____	_____
☐ Arimidex (anastrozole)	1 mg tablet	Take 1 tab PO once daily with or without food	☐ 30 days ☐ _____	_____
☐ Aromasin (exemestane)	25 mg tablet	Take 1 tab PO once daily after a meal		
☐ Femara (letrozole)	2.5 mg tablet	Take 1 tab PO once daily with or without food		
☐ Evista (raloxifene)	60 mg tablet	Take 1 tab PO once daily with or without food	☐ 30 days ☐ _____	_____
☐ Fareston (toremifene)	60 mg tablet	Take 1 tab PO once daily with or without food		
☐ Nolvadex (tamoxifen)	20 mg tablet	☐ Take 1 tab PO once daily with or without food ☐ Other: _____		
☐ Other: _____	_____	_____	_____	_____
☐ Other: _____	_____	_____	_____	_____

Prescriber Information [Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____] Use Cover My Meds: ☐ No ☐ Yes

Name: _____ DEA# _____ 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: