

**New/Changed Dose**

**Cancer – Breast | Afinitor®, Afinitor Disperz®, Capecitabine, Cyclophosphamide, Inluriyo™, Tykerb®**

**Prescriber Information**

Prescriber Name \_\_\_\_\_ MD DO NP PA NPI \_\_\_\_\_  
Office Contact \_\_\_\_\_ Practice Name / Collaborating 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 \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work/Cell \_\_\_\_\_ HIPAA Contact \_\_\_\_\_  
Emergency # \_\_\_\_\_  
Interpreter Needed? Y N | Allergies Y N If Yes, list allergies \_\_\_\_\_

**Insurance Information**

Primary Insurance \_\_\_\_\_ Policy ID \_\_\_\_\_ Group# \_\_\_\_\_  
BIN \_\_\_\_\_ PCN \_\_\_\_\_  
Policyholder Name \_\_\_\_\_ Policyholder DOB / /

**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 Code** \_\_\_\_\_ Weight \_\_\_\_\_ lb kg Height \_\_\_\_\_ in cm  
BSA \_\_\_\_\_ m2 Diagnosis Date / /  
Current SCr \_\_\_\_\_ or current GFR \_\_\_\_\_ ml/min \_\_\_\_\_  
Confirmation Mutations \_\_\_\_\_  
Prior Therapy \_\_\_\_\_  
Reason for Discontinuation of Therapy \_\_\_\_\_  
Approximate Start Date \_\_\_\_\_  
Approximate End Date \_\_\_\_\_

**Prescription Information**

| Medication  | Dose/Strength   | Sig   | Quantity | Refills |
|---|---|---|----------|---------|
| <b>AFINITOR®</b><br>(everolimus)                                | 2.5 mg tablet<br>5 mg tablet<br>7.5 mg tablet<br>10 mg tablet | Take ____ mg by<br>mouth once daily<br>Other: _____   |          |         |
| <b>AFINITOR DISPERZ®</b><br>(everolimus for oral<br>suspension) | 2 mg tablet<br>3 mg tablet<br>5 mg tablett                    | Take ____ mg by<br>mouth once daily<br>Other: _____   |          |         |
| <b>CAPECITABINE</b>   | 150 mg tablet<br>500 mg tablet                                |   |          |         |
| <b>CYCLOPHOSPHAMIDE</b>   | 25 mg capsule<br>50 mg capsule                                |   |          |         |
| <b>INLURIYO™</b><br>(imlunestrant)                              | 200 mg tablet   | Take 1 tablet by<br>mouth daily on an<br>empty stomach<br>Other: _____  |          |         |
| <b>TYKERB®</b><br>(lapatinib)                                   | 250 mg tablet   | Take 1,500 mg (6<br>tablets) by mouth<br>once daily without<br>food (at least 1 hour<br>before or 1 hour after<br>a meal)<br>Other: _____ |          |         |

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

Prescriber Signature \_\_\_\_\_

Prescriber Signature \_\_\_\_\_

Date \_\_\_\_\_

*Substitution Permitted*

Date \_\_\_\_\_

*Dispense as Written*

 If brand is required, please write  
 "DAW" in the box to the right.