

## Physician Request Form Tykerb®

Fax to PerformRx Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

BSA: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg

Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

License #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 Diagnosis Code: \_\_\_\_\_

Sig (How Administered): \_\_\_\_\_

### SELECT APPROPRIATE DIAGNOSES SECTION:

#### A. Breast Cancer:

- Does the patient have advanced and/or metastatic breast cancer? (please check)  Yes  No
- Does the patient have an overexpression of the human epidermal receptor type 2 (HER2) gene? (please check)  Yes  No
- Is the patient any of the following (please check all that apply):
  - Estrogen receptor negative
  - Progesterone receptor negative
  - Refractory to, or failed, prior hormonal treatment
  - Has symptomatic visceral disease
- Has the patient tried/failed prior chemotherapy with Herceptin  Yes (please state what drugs were used, start/end date of therapy and/or duration of therapy) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No, then why \_\_\_\_\_

Is Tykerb being used in combination with Xeloda? (please check)  Yes  No, then why \_\_\_\_\_  
\_\_\_\_\_

#### C. Diagnosis other than Breast Cancer

- Rationale for choosing this treatment, please include all applicable documentation  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_