This form is for treating breast cancer only. Do not complete this for any other cancers use the General PA form.

1) What Stage of Breast Cancer? __________________________

2) What is the Estrogen Receptor Status? ___+  _____-

3) Was there any prior neoplasm drug therapy?  _______________________________________

4) Is there any concurrent combination therapy?  ________yes    _________no
   If yes what? _______________________________________

5) Is the patient on warfarin therapy? ________yes    _________no
   *If yes, what is the INR, and is this being monitor and by whom?
   ____________________________________________________________

6) What is the patient CrCl (Creatinine Clearance)? __________________________
   *(MUST USE COCKCROFT-GAULT FORMULA):
   \[
   \left\lfloor \frac{(140 - \text{Age}) \times \text{Mass (in kg)}}{72 \times \text{Serum creatinine (in mg/dL)}} \right\rfloor
   \]
   If the patient is female, multiply the above by 0.85

7) Requested Dose: _______________________ Quantity________

8) Direction____________________________

9) Total expected length of treatment duration including number of cycles prior to next Staging:  
   ____________________________________________________________

10) Cycle Length: _____________________

11) Date of next Staging: _______________________________________

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I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

Signature of Prescriber __________________________

Date  

FAX TO: District of Columbia Pharmacy Program
Fax: 866-535-7622
PA HELPDESK: 800-273-4962