Paclitaxel - Metastatic Breast Cancer

(This form must be completed **before** the first dose is dispensed.)
## 1. Patient Profile

- **Surname:**  
- **Given Name:**  
- **OHIN:**  
- **Chart Number:**  
- **Postal Code:**  
- **Height (cm):**  
- **Weight (kg):**  
- **BSA (m²):**  
- **Gender:**  
- **Date of Birth:**  
- **Site:**  
- **Attending Physician (MRP- Most Responsible Physician):**

**Requested Prior Approval**  
- Yes  
- No

**Patient on Clinical Trial**  
- Yes  
- No

**Other (specify):**

**Specify Arm:**
- Standard of care arm  
- Experimental arm  
- Blinded / Unknown

**Justification for Funding**

## 2. Eligibility Criteria

Please select one of the following criteria:

- The patient has metastatic breast cancer and will be treated first line with paclitaxel in combination with doxorubicin  
  - Yes
b. The patient has metastatic breast cancer and will be treated with paclitaxel and meets one of the following criteria:

☐ cannot tolerate anthracyclines
☐ has failed anthracycline therapy for metastatic disease
☐ has received an anthracycline as adjuvant therapy

3. Notes

The NDFP will fund only one of the 3 drugs (paclitaxel, docetaxel or vinorelbine) for any metastatic breast cancer patient. Nab-Paclitaxel may be used in place of paclitaxel or docetaxel provided that the patient meets nab-paclitaxel eligibility criteria.

4. Supporting Documents

To ensure reimbursement of your claim, both the completed enrolment form and a copy of the required documentation (where applicable) must be submitted through CCO e-Claims.

Signature of Attending Physician (MRP-Most Responsible Physician): ..................................................

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Day Month Year