Pamidronate - 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:  
  Day  Month  Year  
* 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

Request prior approval for enrolment

* Justification for Funding

2. Eligibility Criteria

The patient must meet criteria a, b and one of c:

a. The patient has metastatic breast cancer  □ Yes
b. The patient has bone metastases

b. Yes

c. The patient:
   - was given oral clodronate and is unable to tolerate it
   - is likely to be unable to tolerate oral clodronate (e.g. the patient is on IV chemotherapy or has pre-existing nausea related to medications or disease)

3. Funded Dose

- Pamidronate 90 mg every 4 weeks, or
- Pamidronate (60-90 mg) every 3 weeks with scheduled chemotherapy

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