Palbociclib treatment for cancer patients

Funding request form

Please complete this form to request funding for Bupa patients who need Palbociclib treatment for hormone receptor positive and HER2 negative locally advanced or metastatic breast cancer. Our policies cover treatment with Palbociclib in line with the manufacturer's guidance.

If the patient's treatment plan isn't in line with the terms of the manufacturer's summary of product characteristics, please complete a **'Funding request form: Out of licence drug/regimen'** instead.

Please type this form and complete all sections. Without the information requested, our funding decision may be delayed. We may need to see a copy of the patient's full medical notes, which we'll ask you for, to confirm that the treatment is covered by the patient's policy.

Then send your completed form and supporting information to us as soon as possible by secure email: **Oncologyteam@bupa.com**

Information you send to this email address may not be secure unless you send us your email through Egress Switch. To sign up for a free Egress Switch account, go to **https://switch.egress.com/ui/learn**

We'll let you know by phone or secure email within two working days of receiving your completed form whether the Bupa patient's treatment is covered by their policy. Please let us know how you'd prefer us to contact you about this?

Phone ☐ or secure email ☐

What's the best phone number/email address to use?

If you've any questions please call us on **0845 850 0465**. We're here between 8am and 6pm Monday to Friday. We may record or monitor our calls.

1. About the patient

Title (please tick)	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ Other (please state)
Name	
Date of birth	D D M M Y Y Y Y
Bupa membership number	

2. Clinician's details

Name of requesting consultant	
Bupa provider number	Specialty
Hospital name	Phone number

3. Questions about the patient and their condition

Does the patient have a diagnosis of hormone receptor positive and her-2 negative breast cancer?	☐ Yes	☐ No
Does the patient have locally advanced or metastatic breast cancer that won't respond to curative treatment?	☐ Yes	☐ No
Has the patient previously been treated with Palbociclib, Ribociclib or Abemaciclib and experienced disease progression?	☐ Yes	☐ No
Is the patient's performance status either 0, 1 or 2?	☐ Yes	☐ No
Is the patient male? If yes, please skip to section 4. Questions about the proposed treatment	☐ Yes	☐ No
If the patient is female, are they post-menopausal?	☐ Yes	☐ No
If the female patient is pre or peri menopausal, have they received ovarian ablation or ovarian hormone suppression treatment, or are they receiving it now?	☐ Yes	☐ No

4. Questions about the proposed treatment

Proposed treatment start date	D D M M Y Y Y Y	
Will this be given in combination with an aromatase inhibitor or fulvestrant and/or an LHRH agonist?	☐ Yes	☐ No
Is the patient likely to have a treatment break of 6 weeks or more?	☐ Yes	☐ No
Will the patient be treated until progressive disease or excessive toxicity or patient choice to discontinue treatment?	☐ Yes	☐ No
Will Palbociclib be otherwise used as set out in the manufacturer's Summary of Product Characteristics (SPC)?	☐ Yes	☐ No

5. Consultant's declaration

Please complete this section to confirm that the information on this form is accurate and not misleading, that you've obtained informed consent from the patient and have explained all the risks and alternatives associated with this treatment.

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity before I submitted this form.

Consultant's name	Date D D M M Y Y Y Y
General Medical Council number	