Breakthrough Cancer Pain Statement

In order to continue assisting your patient, we need to verify the source of his/her breakthrough cancer pain. Please complete, SIGN (required), and UPLOAD this form through the PORTAL or fax it to 800-282-7692.

Section 1: Patient Information

My patient, ____________________ Is being treated for ____________________

Date of Birth: ____________________ Last 4 digits of SSN: xxx-xx-__________

Section 2: Prescribing Provider Information

Prescribing Provider Name, Credentials: ____________________

Facility Name: ____________________

Address: ____________________

City: __________ State: __________ Zip Code: __________

Telephone: ____________________ Fax: ____________________

Email: ____________________

Primary Office Contact (social worker, nurse): ____________________
first and last name preferred; first name and at least last name initial required

Primary Contact Telephone: ____________________ Fax: ____________________

Section 3: Statement

By signing this Breakthrough Cancer Pain Statement, I hereby certify that:

- I am duly licensed and authorized in my state to prescribe **this specific medication(s)** used to treat breakthrough cancer pain,
- The diagnosis listed above is accurate,
- I will be supervising the patient's treatment and **will monitor all opiate analgesics being prescribed** to this patient, and
- The **source of the patient's pain is directly related to the patient's cancer** (i.e. bone metastases or tumor impinging on nerves, bones, or organs).

By signing this Breakthrough Cancer Pain Statement, I hereby certify that I understand that:

- Any identified patterns of inaccurate submissions to the Foundation may result in my – or the entity I represent – termination from the Foundation's program for a length of time as determined by the Foundation.

PLEASE NOTE: Patients are free to change physicians, pharmacies, or the type of medication they are taking at any time

X ____________________ ____________________
Prescriber's Original Signature (STAMPED OR ELECTRONIC SIGNATURES NOT VALID) Date

____________________ ____________________
PRINTED Prescriber's Name Prescriber's Credentials - REQUIRED
(example: MD, DO, NP, PA)