CCC Coder ID: _______

Member ID: __ __ - __ __ __ __ __ - __ Case #: ____________ CCC ID: ____________

Other Case #s: ___________________ Date completed: __ __ / __ __ / __ __ (MM/DD/YY)

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1. Was any breast surgery done as part of primary treatment for breast cancer?
   - ☐$_0$ No
   - ☐$_9$ Unknown if cancer-directed surgery performed (e.g., death certificate ONLY)
   - ☐$_1$ Yes ↓

1.1 Type of surgery: **(Mark all that apply)**

☐$_1$ **Partial mastectomy**
- Lumpectomy, excisional biopsy
- Re-excision
- Segmental
- Wedge resection
- Quadrantectomy
- Tylectomy
- Subcutaneous mastectomy

☐$_2$ **Mastectomy**
- Total (simple) mastectomy, NOS
- Modified radical mastectomy
- Radical mastectomy, NOS
- radical mastectomy
- Mastectomy, NOS

☐$_3$ **Nipple resection** (rare, typically seen with diagnosis of sarcoma)

1.2 Surgery date: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

1.3 With removal of uninvolved contralateral breast? ☐$_0$ No ☐$_1$ Yes

2. Were any molecular tests performed as part of the diagnosis or treatment? (e.g., OncotypeDX, MammaPrint)?
   - ☐$_1$ Yes ↓
   - ☐$_0$ No →
   - ☐$_2$ Recommended, unknown if done
   - ☐$_9$ Unknown

2.1 Indicate reason:
- ☐$_1$ Recommended, insurance denied
- ☐$_2$ Recommended, participant refused
- ☐$_3$ Not recommended
- ☐$_4$ Test not commercially available
- ☐$_8$ Other (**Specify**): ____________________
- ☐$_9$ Unknown

2.2 Specify test:
- ☐$_1$ OncotypeDX
- ☐$_2$ MammaPrint
- ☐$_8$ Other (**Specify**): ______________________________

2.3 Date of test: __ __ / __ __ / __ __ (Month Day Year) ☐$_1$ Exact ☐$_2$ Estimated ☐$_9$ Unknown

2.4 Indicate reason for ordering the test. **(Mark all that apply.)**

- ☐1 Participant request
- ☐2 Clinically indicated – treatment depends on results
- ☐3 Recommended by surgeon
- ☐4 Recommended by oncologist
- ☐5 Recommended, clinician NOS
- ☐6 TailoRx clinical trial
- ☐7 RxPonder clinical trial
- ☐8 Other clinical trial/research
- ☐9 Not documented in records
- ☐10 No medical records available
- ☐88 Other (**Specify**): ______________________

2.5 Test results

- ☐1 Low- risk
- ☐2 Intermediate-risk
- ☐3 High-risk
- ☐4 N/A
- ☐5 Test ordered / results not available

2.6 Is the test score available?

- ☐1 Yes ↓
  - 2.7 Score: _____________
- ☐0 No
- ☐2 Not applicable
- ☐3 Test ordered/results not available

3. Was a second molecular test performed as part of the diagnosis or treatment? (e.g., OncotypeDX, MammaPrint)?

☐1 Yes ↓ ☐0 No

3.1 Specify second test:

- ☐1 OncotypeDX
- ☐2 MammaPrint
- ☐8 Other (**Specify**): ______________________________

3.2 Date of second test: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

3.3 Indicate reason for ordering the second test? **(Mark all that apply.)**

- ☐1 Participant request
- ☐2 Clinically indicated – treatment depends on results
- ☐3 Recommended by surgeon
- ☐4 Recommended by oncologist
- ☐5 Recommended, clinician NOS
- ☐6 TailoRx clinical trial
- ☐7 RxPonder clinical trial
- ☐8 Other clinical trial/research
- ☐9 Not documented in records
- ☐10 No medical records available
- ☐11 First test indeterminate
- ☐88 Other (**Specify**): _____________________

3.4 Second test results

- ☐1 Low- risk
- ☐2 Intermediate-risk
- ☐3 High-risk
- ☐4 N/A
- ☐5 Test ordered/results not available

3.5 Is the second test score available?

- ☐1 Yes ↓
  - 3.6 Score: ________________
- ☐0 No
- ☐2 Not applicable
- ☐3 Test ordered/results not available

4. Was chemotherapy and/or other targeted or specialized therapy administered as part of the first course of therapy (e.g., Doxorubicin, Herceptin)?

- ☐1 No →
- ☐2 Recommended, unknown if done
- ☐9 Unknown
- ☐1 Yes ↓

4.1 Indicate reason:

- ☐1 Participant refused
- ☐2 Not a candidate for treatment
- ☐3 Participant chose alternate recommended treatment
- ☐4 Not indicated based on molecular test
- ☐5 Not recommended
- ☐8 Other (Specify): ________________________
- ☐9 Unknown

4.2 Was there written documentation indicating treatment was based on the molecular test results?

- ☐0 No
- ☐9 Unknown
- ☐1 Yes

→ Record regimen below.

4.3 Regimen/Name: ____ Code: ________

Type: ☐1 Adjuvant therapy ☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

4.4 Regimen/Name: ____ Code: ________

Type: ☐1 Adjuvant therapy ☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

4.5 Regimen/Name: ______________________ Code: ________

Type: ☐1 Adjuvant therapy
☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

4.6 Regimen/Name: ______________________ Code: ________

Type: ☐1 Adjuvant therapy
☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

4.7 Regimen/Name: ______________________ Code: ________

Type: ☐1 Adjuvant therapy
☐2 Neoadjuvant therapy

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

5. Was radiation therapy given as part of the first course of therapy?

☐0 No ⟶
☐2 Recommended, unknown if done
☐9 Unknown
☐1 Yes

5.1 Indicate reason:
☐1 Participant refused
☐2 Participant chose alternate recommended treatment
☐3 Not a candidate for treatment
☐4 Not recommended
☐8 Other (Specify): ______________________
☐9 Unknown

5.2 **(Mark all that apply.)**
☐1 External beam radiation therapy (EBRT)
☐2 Internal radiation therapy (e.g., brachytherapy)
☐3 Radioisotopes
☐8 Other (Specify): ______________________
☐9 Unknown

5.3 Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

Total dosage of radiation received: _________ cGy/Rad ☐9 Unknown

6. Was endocrine-targeted/hormonal therapy administered as part of the first course of therapy (e.g., Tamoxifen [trade names: Nolvadex Istubal, Valodex], Arimidex [anastrazole], Aromasin [exemestane], Femera [letrozole], Lupron [leuprorelin], Evista [raloxifene])?

☐1 Yes ☐0 No ☐9 Unknown

☐2 Recommended, unknown if done

6.1 Agent Name: ______________________ Code: ________

Use: ☐1 Intermittent use ☐2 Continuous use ☐9 Unknown

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date or Last documented use: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐3 Current use ☐9 Unknown

6.1.1 Is there documentation of a **switch** from one endocrine therapy to another as part of the first course of therapy?

☐1 Yes →

6.1.2 Indicate reason for the switch:

☐1 A planned switch ☐8 Other (Specify): ______________

☐2 Adverse event ☐9 Unknown

☐3 Side effects

Go to Question 6.2.

☐0 No →

☐9 Unknown

6.1.3 Complete final disposition:

☐1 Treatment plan completed ☐4 Deceased

☐2 Remains on treatment plan ☐8 Other (Specify): _________

☐3 Side effects ☐9 Unknown

Go to Question 7. **Go to Question 7.**

6.2 Agent Name: ______________________ Code: __________

Use: ☐1 Intermittent use ☐2 Continuous use ☐9 Unknown

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date or Last documented use: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐3 Current use ☐9 Unknown

6.2.1 Is there documentation of a **switch** from one endocrine therapy to another as part of the first course of therapy?

☐1 Yes → 6.2.2 Indicate reason for the switch:
- ☐1 A planned switch
- ☐2 Adverse event
- ☐3 Side effects
- ☐8 Other (**Specify**): ________________
- ☐9 Unknown

↓ **Go to Question 6.3.**

☐0 No → 6.2.3 Complete final disposition:
- ☐1 Treatment plan completed
- ☐2 Remains on treatment plan
- ☐3 Side effects
- ☐4 Deceased
- ☐8 Other (**Specify**): __________
- ☐9 Unknown

↓ **Go to Question 7.**

☐9 Unknown

↓ **Go to Question 7.**

6.3 Agent Name: ____ Code: __________

Use: ☐1 Intermittent use ☐2 Continuous use ☐9 Unknown

Start date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

End date or Last documented use: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐3 Current use ☐9 Unknown

6.3.1 Is there documentation of a **switch** from one endocrine therapy to another as part of the first course of therapy?

☐1 Yes → 6.3.2 Indicate reason for the switch:
- ☐1 A planned switch
- ☐2 Adverse event
- ☐3 Side effects
- ☐8 Other (**Specify**): ________________
- ☐9 Unknown

↓ **Go to Question 7.**

☐0 No → 6.3.3 Complete final disposition:
- ☐1 Treatment plan completed
- ☐2 Remains on treatment plan
- ☐3 Side effects
- ☐4 Deceased
- ☐8 Other (**Specify**): __________
- ☐9 Unknown

☐9 Unknown

7. Did the participant have ovarian removal as part of treatment for her breast cancer?

☐1 Yes ↓
☐0 No
☐2 Recommended, unknown if done
☐9 Unknown

7.1 Type of ovarian removal:

☐1 Bilateral/unilateral* oophorectomy *(Includes radical hysterectomy)* →

**See coding instructions*

7.1.2 Date of surgery: __ __ / __ __ / __ __
Month Day Year

☐1 Exact ☐2 Estimated ☐9 Unknown

☐8 Other **(Specify)**:

____

☐9 Unknown

8. Was breast reconstruction surgery documented in the medical record?

☐1 Yes ↓
☐0 No
☐9 Unknown

8.1 What type of reconstruction was documented? **(Mark all that apply.)**

☐1 Saline implant(s)
☐2 Silicone implant(s)
☐3 Implant(s), type unspecified
☐4 TRAM flap (or transverse rectus abdominis muscle flap)
☐5 Latissimus dorsi flap
☐6 DIEP (deep inferior epigastric artery perforator) flap
☐7 Gluteal free flap
☐8 Inner thigh or TUG flap
☐9 Flap procedure, details not specified
☐88 Other **(Specify)**: ____
☐99 Unknown type

8.2 Was the first reconstruction surgery performed concurrently with resection ("One stage")?

☐1 Yes
☐0 No →

8.3 Date of reconstruction surgery: __ __ / __ __ / __ __
Month Day Year

☐1 Exact ☐2 Estimated ☐9 Unknown

9. After diagnosis, was the participant treated with any medications to prevent bone loss, such as bisphosphonates, as part of the first course of therapy? (Not for recurrence)

☐1 Yes ↓ ☐0 No
☐2 Recommended, unknown if done
☐9 Unknown

9.1 Specify type(s) of medication: **(Mark all that apply.)**

☐1 Alendronate (Fosamax)
☐2 Clodronate (Bonefos, Loron)
☐3 Denosumab (Prolia, Xgeva)
☐4 Etidronate (Didronel)
☐5 Ibandronate (Boniva)
☐6 Neridronate (Nerixia)
☐7 Olpadronate
☐8 Pamidronate (APD, Aredia)
☐9 Risedronate (Actonel)
☐10 Tiludronate (Skelid)
☐11 Zoledronic Acid (Zometa, Aclasta)
☐88 Other **(Specify)**: ______________________________
☐99 Unknown type

9.2 Administration route: **(Mark all that apply.)**

☐1 Oral
☐2 Intravenous (IV)
☐3 Subcutaneous injection (SQ)
☐4 Combined
☐8 Other **(Specify)**: ______________________________
☐9 Unknown

9.3 First date prescribed: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

Last date prescribed: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

10. Has the participant ever been disease free since her initial diagnosis/treatment?

☐1 Yes → 10.1 Date as documented in the medical records *: __ __ / __ __ / __ __ (Month Day Year)
☐0 No
☐9 Unknown

*If no evidence of recurrence or metastasis: Record **most recent** documented disease free date. If documented recurrence or metastasis: Record **first** known disease free date

11. Was there a new or recurrent invasive breast cancer diagnosed after a documented disease free interval?

☐0 No
☐9 Unknown
☐1 Yes

11.1 Laterality: ☐1 Ipsilateral ☐2 Contralateral ☐9 Unknown
Histology: ☐1 Same ☐2 Different ☐9 Unknown
Specify histology: ________________________________
Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

11.2 Laterality: ☐1 Ipsilateral ☐2 Contralateral ☐9 Unknown
Histology: ☐1 Same ☐2 Different ☐9 Unknown
Specify histology: ________________________________
Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

11.3 Laterality: ☐1 Ipsilateral ☐2 Contralateral ☐9 Unknown
Histology: ☐1 Same ☐2 Different ☐9 Unknown
Specify histology: ________________________________
Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

12. Did a metastasis occur outside the primary breast after a documented disease free interval?

☐1 Yes ☐0 No ☐9 Unknown

12.1 Site: **(Mark all that apply.)**

☐1 Chest wall
☐2 Contralateral breast (rare)
☐3 Liver
☐4 Bone
☐5 Lung
☐6 Regional lymph node
☐7 Distant lymph node
☐8 Brain
☐88 Other (**Specify**): ____________________________

12.2 Diagnosis date: __ __ / __ __ / __ __ (Month Day Year) ☐1 Exact ☐2 Estimated ☐9 Unknown

Comments: