Urologic Oncology Enrollment Form

InfuCare Rx

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Website: www.InfuCareRx.com

PATIENT INFORMATION				PRESCRIBER INFORMATION		
Name:				Prescribing Practitioner:		NPI:
Address:				Address:		
City:	State/Zip:			City:		State/Zip:
Telephone:	DOB:	M ☐ F ☐		Office:		DEA:
Language Preference:	Wt:	Ht:		Contact:	Phone:	Fax:

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRIMARY INSURANCE INFORMATION

Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PRESCRIPTION

New ☐ Refill ☐ | Ship by: | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug	Strength	Directions & Quantity	Refills
Zytiga®	☐ 250 mg film-coated tablets ☐ 250 mg uncoated tablets ☐ 500 mg film-coated tablets	☐ Take 1,000 mg (FOUR 250 mg tablets) once daily by mouth on an empty stomach (Qty: 120) ☐ Take 1,000 mg (TWO 500 mg tablets) once daily by mouth on an empty stomach (Qty: 60)	
Prednisone®	☐ 5 mg tablets	☐ Take 5 mg twice daily by mouth with food (Qty: 60) ☐ Take 5 mg once daily by mout with food (Qty: 30)	
Yonsa®	☐ 125 mg tablets	☐ Take 500 mg (FOUR 125 mg tablets) once daily by mouth (Qty: 120)	
Methylprednisolone®	☐ 4 mg tablets	☐ Take 4 mg twice daily by mouth (Qty: 60)	
Other:_____			

ADDITIONAL MEDICATIONS

Drug	Directions	Quantity	Refills
Casodex (bicalutiamide)			
Firmagon (degarelix)			
Lupron Depot (leuprolide)			
Nilandron (nilatamide)			
Zoladex (goserelin)			
Other:			

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

Previous Therapies: ☐ ☐

Tried & Failed (Duration): ☐ (_____) ☐ (_____)

Not Tolerated: ☐ ☐

Contraindication: _____ _____

Prior Medication Failed: _____

Length of Treatment:_____

Reason for Discontinuation: _____

Date of Diagnosis:_____

☐ Patient has metastic castration-resistant prostate cancer (mCRPC)

☐ Patient has metastic castration-sensitve prostate cancer (mCSPC)

Diagnosis:

☐ C61 Malignant neoplasm of prostate

☐ Other: _____

Diabetes: ☐ Yes ☐ No

Liver Dysfunction: ☐ Yes ☐ No

If yes, indicate the child-turcotte-pugh class ☐ A ☐ B ☐ C

	Latest Value	Date
Serum PSA:		

Allergies:

PATIENT CONSENT TO MANUFACTURER SUPPORT PROGRAMS

By signing this form and utilizing our services, you authorize FOSRX/FAST Pharmacy to access and enroll you in available manufacturer supported patient programs in your behalf.

Signature: **Date:**

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: **Date:**