InfuCare Rx

Urologic Oncology Referral Form

of Pages Faxed:_____
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required:_____ Ship To: ☐ Patient ☐ MD Office ☐ Other:_____

PATIENT INFORMATION

Patient Name:_____
Address:_____
City, State, Zip:_____
Home Phone:_____
Cell Phone:_____
Date of Birth:_____ ☐ Male ☐ Female
Emergency Contact:_____ Phone:_____

PRESCRIBER INFORMATION

Prescriber Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____
DEA #:_____ NPI #:_____
Contact Person:_____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance:_____ ID:_____ Group:_____
Secondary Insurance:_____ ID:_____ Group:_____
Prescription Card:_____ ID:_____ BIN:_____ PCN:_____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ C61 Malignant neoplasm of prostate
☐ Other:_____
Prior Medication Failed:_____
Length of Treatment:_____
Reason for Discontinuation:_____

Previous Therapies:	Tried & Failed (Duration):	Not Tolerated:	Contraindication:
_____	☐ (_____)	☐	_____
_____	☐ (_____)	☐	_____
_____	☐ (_____)	☐	_____

Weight:_____ ☐ kg ☐ lbs Height:_____ ☐ cm ☐ in %BSA:_____
Allergies:_____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other:_____
☐ metastic castration-resistant prostate cancer (mCRPC)
☐ metastic castration-sensitve prostate cancer (mCSPC)
☐ Diabetes ☐ Liver Dysfunction If yes, indicate the child-turcotte-pugh class ☐ A ☐ B ☐ C
Serum PSA: Latest Value:_____ Date:_____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	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

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

ADDITIONAL COMMENTS

Prescriber Signature:_____ **Date:**_____