Urologic Oncology Enrollment Form

Fax Referral To: 844-504-3278
Phone: 877-327-8881

Please cut along the dotted lines before submitting to a pharmacy.

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

PATIENT INFORMATION

Patient Name: ____________
Address: ____________
City, State, Zip: ____________
Home Phone: ____________
Cell Phone: ____________
Date of Birth: ____________ Gender: ____________
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:** ____________

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