InfuCare Rx®

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:** _____