



Prostate Cancer Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name: _____ DOB: _____
 SSN: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 Known Allergies: _____
 Height: _____ Weight: _____ lbs. ☐ M ☐ F
 Emergency Contact: _____
 Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____
 Secondary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI#: _____ DEA#: _____ TAX ID: _____
 Address: _____ City, State, Zip: _____
 Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

Primary Diagnoses: _____ Primary ICD-10: _____ Secondary ICD-10: _____
 Prior Therapies: _____ Reasons for Discontinuation: _____
 Prior Therapies: _____ Reasons for Discontinuation: _____
 Comorbidities: _____ Known Allergies: _____

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> 250 mg tablets <input type="checkbox"/> 500 mg tablets	<input type="checkbox"/> Take 1,000 mg orally once daily on an empty stomach <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Prednisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Akeega™ (niraparib and abiraterone acetate)	<input type="checkbox"/> 50 mg niraparib/500 mg abiraterone acetate tablets <input type="checkbox"/> 100 mg niraparib/500 mg abiraterone acetate tablets	<input type="checkbox"/> Take _____ tablet(s) orally once daily 1 hour before or 2 hours after a meal <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Prednisone	<input type="checkbox"/> 10 mg tablets	<input type="checkbox"/> Take 10 mg orally once daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Doxetaxel				
<input type="checkbox"/> Erleada® (apalutamide)	<input type="checkbox"/> 60 mg tablets <input type="checkbox"/> 240 mg tablets	<input type="checkbox"/> Take 240 mg orally once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Jevtana® (cabazitaxel)	<input type="checkbox"/> 60 mg/1.5mL single dose vial, supplied with diluent (5.7 mL)	<input type="checkbox"/> _____ mg/m ² infused every 3 weeks		
<input type="checkbox"/> with Predisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Mitoxantrone	<input type="checkbox"/> 20 mg/10 mL vial <input type="checkbox"/> 30 mg/15 mL vial <input type="checkbox"/> 25 mg/12.5 mL vial	<input type="checkbox"/> _____ mg/m ² infused every 3 weeks		
<input type="checkbox"/> Nubeqa® (darolutamide)	<input type="checkbox"/> 300 mg tablets	<input type="checkbox"/> Take 600 mg orally twice daily with food <input type="checkbox"/> Other: _____		

DELIVERY INFORMATION

Need by: _____ Deliver to: ☐ Patient's home ☐ MD Office/ Clinic ☐ Other: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: _____ ☐ DAW Date: _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

ON-822 6.24

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws.

If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.



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<input type="checkbox"/> Orgovyx® (relugolix) (Cycle 1 only)	<input type="checkbox"/> 120 mg tablets	<input type="checkbox"/> Take 360 mg orally on the first day of treatment followed by 120 mg taken orally once daily at approximately the same time each day	30	0
<input type="checkbox"/> Orgovyx® (relugolix) (Maintenance Cycles) *Patient has completed the loading dose	<input type="checkbox"/> 120 mg tablets	<input type="checkbox"/> Take 120 mg orally once daily at approximately the same time each day		
<input type="checkbox"/> Prednisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Trelstar® (triptorelin pamoate for injectable suspension)	<input type="checkbox"/> 3.75 mg with MIXJECT single dose delivery system <input type="checkbox"/> 11.25 mg with MIXJECT single dose delivery system <input type="checkbox"/> 22.5 mg with MIXJECT single dose delivery system	<input type="checkbox"/> Inject intramuscularly 3.75 mg every 4 weeks <input type="checkbox"/> Inject intramuscularly 11.25 mg every 12 weeks <input type="checkbox"/> Inject intramuscularly 22.5 mg every 24 weeks		
<input type="checkbox"/> Xtandi® (enzalutamide)	<input type="checkbox"/> 40 mg tablets <input type="checkbox"/> 40 mg capsules <input type="checkbox"/> 80 mg tablets	<input type="checkbox"/> Take 160 mg orally once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Zytiga® (abiraterone acetate)	<input type="checkbox"/> 250 mg tablets <input type="checkbox"/> 500 mg tablets	<input type="checkbox"/> Take 1,000 mg orally once daily on an empty stomach <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Prednisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other				

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