



FACTOR ONE SOURCE
FAST
PHARMACY

PRESCRIBER INFORMATION:

Prescriber Name: _____ Tax ID: _____
Address: _____
Phone #: _____ Fax #: _____
Contact Name: _____ NPI#: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____
Male: _____ Female: _____ Tel: _____ Alt Tel: _____
Address: _____
City/State/Zip: _____
SS#: _____ Wt: _____ Ht: _____ Preferred Language: _____

PRESCRIPTION

New: ___ Refill: ___ Ship by: ___/___/___ Ship to: Patient's Home ___ Doctor's Office ___ Other: _____

Drug		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 mouth 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)	

ADDITIONAL MEDICATIONS

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

MEDICAL INFORMATION:

Previous Therapies:	Duration:	Not Tolerated:	Reasons for Discontinuation:

___ Patient has not tried or failed any prior medications. **Date of diagnosis:** ___/___/___ **Diagnosis:** ___ C61 Malignant neoplasm of prostate ___ Other _____ Patient has metastatic castration-resistant prostate cancer (mCRPC) ___ Patient has metastatic castration-sensitive prostate cancer (mCSPC)

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

Signature: _____ Date: ___/___/___

Prescribing Practitioner Signature

Signature: _____ Date: ___/___/___

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.

By signing this form and utilizing our services, you authorize FOSRX/FAST Pharmacy to serve as your prior authorization agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

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