UROLOGIC ONCOLOGY FORM

Phone: 1-877-327-8881 | Fax: 1-844-504-3278 | www.fosrxfast.com

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 (bicalutiamide)			
Firmagon (degarelix)			
Lupron Depot (leuprolide)			
Nilandron (nilatamide)			
Zoladex (goserelin)			

MEDICAL INFORMATION:

Prevoius 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)
Allergies:

	Latest Value	Date
Serum PSA:		___/___/___

Patient Consent to Manufacturer Support Programs

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.

Prescribing Practitioner Signature

Signature: _____ **Date:** ___/___/___

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 insurace companies, and co-pay assistance foundations.