# Urologic Oncology Enrollment Form

FACTOR ONE SOURCE FAST PHARMACY

Powered By: InfuCare Rx

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**Fax:** 1-844-504-3278
**Website:** www.FOSRXFAST.com

**Louisiana Office**
2400 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

## PATIENT INFORMATION

| | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| City: | State/Zip: | | |
| Telephone: | DOB: | M ☐ F ☐ | |
| Language Preference: | Wt: | Ht: | |

## PRESCRIBER INFORMATION

| | | | |
|---|---|---|---|
| Prescribing Practitioner: | | NPI: | |
| Address: | | | |
| City: | | State/Zip: | |
| Office: | | DEA: | |
| Contact: | Phone: | Fax: | |

## PRIMARY INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Member Name: | M ☐ F ☐ | DOB: | |
| Address: | City: | | |
| State: | Zip: | Telephone: | Alt. Telephone: |
| Member ID: | Rx Group #: | BIN#: | |
| PCN#: | Customer Service #: | Please attach a copy of the front and back of the patient's insurance card, if available.***** | |

## PRESCRIPTION

New ☐ Refill ☐ | Ship by: | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

| Drug | Strength | Directions & Quantity | Refills |
|---|---|---|---|
| Zytiga® | ☐ 250 mg film-coated tablets<br>☐ 250 mg uncoated tablets<br>☐ 500 mg film-coated tablets | ☐ Take 1,000 mg (FOUR 250 mg tablets) once daily by mouth on an empty stomach (Qty: 120)<br>☐ 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)<br>☐ 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

| Drug | Directions | Quantity | Refills |
|---|---|---|---|
| Casodex (bicalutiamide) | | | |
| Firmagon (degarelix) | | | |
| Lupron Depot (leuprolide) | | | |
| Nilandron (nilatamide) | | | |
| Zoladex (goserelin) | | | |
| Other: | | | |

## DIAGNOSIS AND CLINICAL INFORMATION

*****PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY**

**Previous Therapies:** | **Tried & Failed (Duration):** | **Not Tolerated:** | **Contraindication:**

☐ ☐ (_____) ☐ _____
☐ ☐ (_____) ☐ _____

Prior Medication Failed: _____
Length of Treatment:_____
Reason for Discontinuation: _____
Date of Diagnosis:_____

☐ Patient has metastic castration-resistant prostate cancer (mCRPC)
☐ Patient has metastic castration-sensitve prostate cancer (mCSPC)

**Diagnosis:**
☐ C61 Malignant neoplasm of prostate
☐ Other: _____

**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

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.

**Signature:** **Date:**

## PRESCRIBING PRACTITIONER SIGNATURE

**To Prescribing Practitioner:** By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

**Prescribing Practitioner Signature:** **Date:**