Kroger specialty pharmacy

# Urology A-G

Lake Mary, FL **toll free** 888.506.2962 **toll free fax** 888.315.3270 **krogerspecialtypharmacy.com**

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

## Patient Information

| | |
|---|---|
| Patient Name | |
| Address | |
| City State Zip | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐ Male ☐ Female |

## Prescriber Information

| | | |
|---|---|---|
| Prescriber Name | | |
| Address | | |
| City State Zip | | |
| Phone | Fax | |
| Contact Person | | |
| DEA # | NPI # | License # |

## Clinical Information

| | | | |
|---|---|---|---|
| Diagnosis | | | ICD-10 |
| Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____<br>_____ Length of Treatment: _____ Reason for Discontinuing: _____<br>_____ Length of Treatment: _____ Reason for Discontinuing: _____ | | | |
| Serum PSA Level | Date Obtained | Weight ☐ kg ☐ lbs | Height ☐ ft ☐ in |
| Gleason Score | ☐ Confirmed HRR Mutation | Has the patient had a bilateral orchiectomy? ☐ No ☐ Yes | Is the medication given in combination with androgen deprivation therapy? ☐ No ☐ Yes |
| Is the prostate cancer metastic? ☐ No ☐ Yes | Is there documented evidence of one or more metastatic bone lesions? ☐ No ☐ Yes | Is the prostate cancer castration-resistant? ☐ No ☐ Yes | Is the prostate cancer castration-sensitive? ☐ No ☐ Yes |
| Drug Allergies | | | Status: ☐ New ☐ Restart ☐ Continuing |

## Prescription Information

| | | | Qty | Refills |
|---|---|---|---|---|
| ☐ Afinitor® | ☐ 2.5mg Tablets<br>☐ 5mg Tablets<br>☐ 7.5mg Tablets<br>☐ 10mg Tablets | ☐ Take 1 tablet by mouth once daily<br>☐ Other: _____ | 28 Tablets<br>_____ | _____<br>_____ |
| ☐ Avastin®<br>*Biosimilars:*<br>☐ *Mvasi®* ☐ *Zirabev®* | _____ mg/kg | ☐ Infuse _____ mg intravenously over 90 minutes every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Eligard® | ☐ 7.5mg Syringe (1 month supply)<br>☐ 22.5mg Syringe (3 month supply)<br>☐ 30mg Syringe (4 month supply)<br>☐ 45mg Syringe (6 month supply) | ☐ Administer 7.5mg subcutaneously once a month<br>☐ Administer 22.5mg subcutaneously every 3 months<br>☐ Administer 30mg subcutaneously every 4 months<br>☐ Administer 45mg subcutaneously every 6 months | 1 Syringe<br>1 Syringe<br>1 Syringe<br>1 Syringe | _____<br>_____<br>_____<br>_____ |
| ☐ Erleada® | ☐ 60mg Tablets<br>☐ 240mg Tablets | ☐ Take 4 tablets (240mg) by mouth once daily<br>☐ Take 1 tablet (240mg) by mouth once daily | 120 Tablets<br>30 Tablets | _____<br>_____ |
| ☐ Firmagon® | ☐ 120mg Vial<br>☐ 80mg Vial | ☐ Loading Dose: Administer 240mg given as two subcutaneous injections of 120mg each<br>☐ Maintenance Dose: Administer 80mg subcutaneously every 28 days, starting on day 29 | 2 Vials<br>1 Vial | None<br>_____ |
| ☐ Other | | | | |



Prescriber's Signature (no stamps) _____ Substitution Permitted _____ Date _____

Prescriber's Signature (no stamps) _____ Dispense As Written _____ Date _____

Kroger specialty pharmacy

# Urology H-O

Lake Mary, FL **toll free** 888.506.2962 **toll free fax** 888.315.3270 **krogerspecialtypharmacy.com**

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

## Patient Information

| | |
|---|---|
| Patient Name | |
| Address | |
| City State Zip | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐ Male ☐ Female |

## Prescriber Information

| | | |
|---|---|---|
| Prescriber Name | | |
| Address | | |
| City State Zip | | |
| Phone | Fax | |
| Contact Person | | |
| DEA # | NPI # | License # |

## Clinical Information

| | | | |
|---|---|---|---|
| Diagnosis | | | ICD-10 |
| Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____<br>_____ Length of Treatment: _____ Reason for Discontinuing: _____<br>_____ Length of Treatment: _____ Reason for Discontinuing: _____ | | | |
| Serum PSA Level | Date Obtained | Weight ☐ kg ☐ lbs | Height ☐ ft ☐ in |
| Gleason Score | ☐ Confirmed HRR Mutation | Has the patient had a bilateral orchiectomy? ☐ No ☐ Yes | Is the medication given in combination with androgen deprivation therapy? ☐ No ☐ Yes |
| Is the prostate cancer metastic? ☐ No ☐ Yes | Is there documented evidence of one or more metastatic bone lesions? ☐ No ☐ Yes | Is the prostate cancer castration-resistant? ☐ No ☐ Yes | Is the prostate cancer castration-sensitive? ☐ No ☐ Yes |
| Drug Allergies | | | Status: ☐ New ☐ Restart ☐ Continuing |

## Prescription Information

| | | | Qty | Refills |
|---|---|---|---|---|
| ☐ Inlyta® | ☐ 1mg Tablets<br>☐ 5mg Tablets | ☐ Take 1 tablet by mouth twice daily<br>☐ Other: _____ | 60 Tablets<br>_____ | _____<br>_____ |
| ☐ Keytruda® | _____ mg | ☐ Infuse _____ mg intravenously every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Lenvima® | ☐ 4mg Daily Dose<br>☐ 8mg Daily Dose<br>☐ 10mg Daily Dose<br>☐ 12mg Daily Dose<br>☐ 14mg Daily Dose<br>☐ 18mg Daily Dose<br>☐ 20mg Daily Dose<br>☐ 24mg Daily Dose | ☐ Take one capsule (4mg) by mouth once daily<br>☐ Take two 4mg capsules (8mg total) by mouth once daily<br>☐ Take one capsule (10mg) by mouth once daily<br>☐ Take three 4mg capsules (12mg total) by mouth once daily<br>☐ Take one 4mg capsule and one 10mg capsule (14mg total) by mouth once daily<br>☐ Take two 4mg capsules and one 10mg capsule (18mg total) by mouth once daily<br>☐ Take two 10mg capsules (20mg total) by mouth once daily<br>☐ Take two 10mg capsules and one 4mg capsule (24mg total) by mouth once daily<br>☐ Other: _____ | 30 Capsules<br>60 Capsules<br>30 Capsules<br>90 Capsules<br>60 Capsules<br>90 Capsules<br>60 Capsules<br>90 Capsules<br>_____ | _____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |
| ☐ Lupron Depot® | ☐ 7.5mg Syringe (1 month supply)<br>☐ 22.5mg Syringe (3 month supply)<br>☐ 30mg Syringe (4 month supply)<br>☐ 45mg Syringe (6 month supply) | ☐ Administer 7.5mg intramuscularly once a month<br>☐ Administer 22.5mg intramuscularly every 3 months<br>☐ Administer 30mg intramuscularly every 4 months<br>☐ Administer 45mg intramuscularly every 6 months | 1 Syringe<br>1 Syringe<br>1 Syringe<br>1 Syringe | _____<br>_____<br>_____<br>_____ |
| ☐ Nexavar® (sorafenib)<br>*Generic only | 200mg Tablets | ☐ Take 2 tablets (400mg) by mouth twice daily<br>☐ Other: _____ | 120 Tablets | _____ |
| ☐ Nilandron® | 150mg Tablets | ☐ Initial: Take 2 tablets (300mg total) by mouth once daily for 30 days<br>☐ Maintenance: Take 1 tablet by mouth once daily | 60 Tablets<br>30 Tablets | None<br>_____ |
| ☐ Opdivo® | _____ mg/kg | ☐ Infuse _____ mg intravenously over 30 minutes every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Other | | | | |



_____ Prescriber's Signature (no stamps) Substitution Permitted _____ Date _____ Prescriber's Signature (no stamps) Dispense As Written _____ Date

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# Urology P-Z

Lake Mary, FL **toll free** 888.506.2962 **toll free fax** 888.315.3270 **krogerspecialtypharmacy.com**

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

## Patient Information

| | |
|---|---|
| Patient Name | |
| Address | |
| City State Zip | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐ Male ☐ Female |

## Prescriber Information

| | | |
|---|---|---|
| Prescriber Name | | |
| Address | | |
| City State Zip | | |
| Phone | Fax | |
| Contact Person | | |
| DEA # | NPI # | License # |

## Clinical Information

| | | | |
|---|---|---|---|
| Diagnosis | | | ICD-10 |
| Prior Failed Meds: _____ Length of Treatment: _____ Reason for Discontinuing: _____ | | | |
| _____ Length of Treatment: _____ Reason for Discontinuing: _____ | | | |
| _____ Length of Treatment: _____ Reason for Discontinuing: _____ | | | |
| Serum PSA Level | Date Obtained | Weight ☐ kg ☐ lbs | Height ☐ ft ☐ in |
| Gleason Score | ☐ Confirmed HRR Mutation | Has the patient had a bilateral orchiectomy? ☐ No ☐ Yes | Is the medication given in combination with androgen deprivation therapy? ☐ No ☐ Yes |
| Is the prostate cancer metastic? ☐ No ☐ Yes | Is there documented evidence of one or more metastatic bone lesions? ☐ No ☐ Yes | Is the prostate cancer castration-resistant? ☐ No ☐ Yes | Is the prostate cancer castration-sensitive? ☐ No ☐ Yes |
| Drug Allergies | | | Status: ☐ New ☐ Restart ☐ Continuing |

| | | Prescription Information | Qty | Refills |
|---|---|---|---|---|
| ☐ Sutent® | ☐ 12.5mg Capsules<br>☐ 25mg Capsules<br>☐ 37.5mg Capsules<br>☐ 50mg Capsules | ☐ Take 1 capsule by mouth once daily for 4 weeks on-treatment, followed by 2 weeks off-treatment<br>☐ Other: _____ | 28 Capsules<br>_____ | _____<br>_____<br>_____<br>_____ |
| ☐ Tecentriq® | _____ mg | ☐ Infuse _____ mg intravenously over 60 minutes every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Torisel® | 25mg/mL Vial | ☐ Infuse _____ mg intravenously over 30 to 60 minutes every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Trelstar® | ☐ 3.75mg Mixject<br>☐ 11.25mg Mixject<br>☐ 22.5mg Mixject | ☐ Administer 3.75mg intramuscularly once every 4 weeks<br>☐ Administer 11.25mg intramuscularly once every 12 weeks<br>☐ Administer 22.5mg intramuscularly once every 24 weeks | 1 Inj. Suspension<br>1 Inj. Suspension<br>1 Inj. Suspension | _____<br>_____<br>_____ |
| ☐ Votrient® | 200mg Tablet | ☐ Take 4 tablets (800mg) by mouth once daily without food (at least 1 hour before or 2 hours after a meal)<br>☐ Other: _____ | 120 Tablets<br>_____ | _____ |
| ☐ Xgeva® | 120mg/1.7mL Vial | Inject 120mg subcutaneously once every 4 weeks | 1 Vial | _____ |
| ☐ Xtandi® | ☐ 40mg Capsules<br>☐ 40mg Tablets<br>☐ 80mg Tablets | ☐ Take 4 capsules (160mg) by mouth once daily<br>☐ Take 4 tablets (160mg) by mouth once daily<br>☐ Take 2 tablets (160mg) by mouth once daily | 120 Capsules<br>120 Tablets<br>60 Tablets | _____<br>_____<br>_____ |
| ☐ Yervoy® | _____ mg/kg | ☐ Infuse _____ mg intravenously over 30 minutes every _____ days<br>☐ Other: _____ | #QS _____ days | _____ |
| ☐ Yonsa®<br>*Prescribe Methylprednisolone below, as needed* | 125mg Tablets | Take 4 tablets (500mg) by mouth once daily | 120 Tablets | _____ |
| ☐ Zoladex® | ☐ 3.6mg Implant Syringe<br>(1 month supply)<br>☐ 10.8mg Implant Syringe<br>(3 month supply) | | _____<br>_____ | _____<br>_____ |
| ☐ Zytiga®<br>*Prescribe Prednisone below, as needed* | ☐ 250mg Tablets<br>☐ 500mg Tablets | ☐ Take 4 tablets (1000mg) by mouth once daily on an empty stomach<br>☐ Take 2 tablets (1000mg) by mouth once daily on an empty stomach | 120 Tablets<br>60 Tablets | _____<br>_____ |
| *Supportive Therapies*<br>☐ Casodex®<br>☐ Methylprednisolone<br>☐ Prednisone | 50mg Tablets<br>4mg Tablets<br>5mg Tablets | Take 1 tablet by mouth once daily<br>Take 1 tablet by mouth twice daily with food<br>Take 1 tablet by mouth twice daily with food | 30 Tablets<br>60 Tablets<br>60 Tablets | _____<br>_____<br>_____ |
| ☐ Other | | | | |

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_____ _____ _____ _____

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date