



SPECIALTY PHARMACY

Lake Mary, FL toll free

UROLOGY

toll free fax :

krogerspecialtypharmacy.com

DATE: _____ NEEDS BY DATE: _____ SHIP TO: PATIENT OFFICE OTHER _____

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____ (ICD-10): _____

Serum PSA Level: _____ Date Obtained: _____ Height: _____ Weight: _____

Drug Allergies: _____

Prior Failed Meds: _____ Length of Treatment _____ Reason for Discontinuing _____
 _____ Length of Treatment _____ Reason for Discontinuing _____
 _____ Length of Treatment _____ Reason for Discontinuing _____

Is the prostate cancer metastatic? Yes No Is the prostate cancer castration-resistant? Yes No

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Casodex*	50mg tablets	Take 1 tablet by mouth once daily	30	_____
<input type="checkbox"/> Eligard*	<input type="checkbox"/> 7.5mg syringe (1 month supply) <input type="checkbox"/> 22.5mg syringe (3 month supply) <input type="checkbox"/> 30mg syringe (4 month supply) <input type="checkbox"/> 45mg syringe (6 month supply)	Administer subcutaneously once a month Administer subcutaneously every 3 months Administer subcutaneously every 4 months Administer subcutaneously every 6 months	1 1 1 1	_____ _____ _____ _____
<input type="checkbox"/> Erleada™	60mg tablets	Take 4 (240mg) tablets (swallow whole) by mouth once daily with or without food	120	_____
<input type="checkbox"/> Firmagon*	<input type="checkbox"/> 120mg vial <input type="checkbox"/> 80mg vial	Loading Dose: Administer subcutaneously two-120 mg (240 mg) doses Maintenance Dose: Administer subcutaneously 80mg every 28 days	2 1	none _____
<input type="checkbox"/> Lupron Depot*	<input type="checkbox"/> 7.5mg kit (1 month supply) <input type="checkbox"/> 22.5mg kit (3 month supply) <input type="checkbox"/> 30mg kit (4 month supply) <input type="checkbox"/> 45mg kit (6 month supply)	Administer intramuscularly once a month Administer intramuscularly every 3 months Administer intramuscularly every 4 months Administer intramuscularly every 6 months	1 1 1 1	_____ _____ _____ _____
<input type="checkbox"/> Nilandron*	150mg tablets		_____	_____
<input type="checkbox"/> Xgeva*	120mg/1.7mL vial		_____	_____
<input type="checkbox"/> Xtandi*	40mg capsules	Take 4 capsules (160mg) by mouth once daily	120	_____
<input type="checkbox"/> Yonsa*	125mg capsules	Take 4 capsules (500mg) by mouth once daily	120	_____
<input type="checkbox"/> Zoladex*	<input type="checkbox"/> 3.6mg implant syringe (1 month supply) <input type="checkbox"/> 10.8mg implant syringe (3 month supply)		_____ _____	_____ _____
<input type="checkbox"/> Zytiga*	<input type="checkbox"/> 250mg tablets <input type="checkbox"/> 500mg tablets	Take 4 tablets (1000mg) once daily by mouth on an empty stomach Take 2 tablets (1000mg) once daily by mouth on an empty stomach	120 60	_____ _____
<input type="checkbox"/> Methylprednisolone	4mg tablets	Take 1 tablet by mouth twice daily with food	_____	_____
<input type="checkbox"/> Prednisone	5mg tablets	Take 1 tablet by mouth twice daily with food	60	_____
<input type="checkbox"/> Other			_____	_____

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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

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