

DATE: _____ NEEDS BY DATE: _____

Patient Information

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

Provider Information

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

Clinical Information

Diagnosis Code: _____ Allergies: _____

Treatment Naïve? _____ Previously Treated?: _____

Prior treatment used: _____

Renal Dysfunction: Yes ___ No ___ Liver Dysfunction: Yes ___ No ___

H/H (Hemoglobin/Hematocrit): _____

Date and value of last HbA1c _____

Date and value of last Serum PSA _____

Date and value of last Serum Testosterone _____

Date of Orchiectomy ____/____/____

Current GnRH antagonist therapy:

Lupron Zoladex Firmagon OR Bilateral Orchiectomy

Duration of previous therapy: From _____ to _____

Total of: _____ months

Product	Quantity	Prescription Information	Supply	Refills
<input type="radio"/> Zytiga	<input type="radio"/> 250mg <input type="radio"/> 500mg	____ Take 4 tablets by mouth daily with food. ____ Take 2 tablets by mouth daily with food.		
<input type="radio"/> Abiraterone		____ Take ____ tablets by mouth daily with food.		
<input type="radio"/> Xtandi	<input type="radio"/> 40mg	Take ____ capsules by mouth daily with or without food.		
<input type="radio"/> Erleada	<input type="radio"/> 60mg	____ Take 4 tablets by mouth daily with food. ____ Take 3 tablets by mouth daily with food.		
<input type="radio"/> Nilandron®	glecaprevir/pibrentasvir 100mg/40mg	____ 300mg PO once daily for 30 days, then 150mg PO once daily. ____ 150 mg PO once daily.		
<input type="radio"/> Lupron				
<input type="radio"/> Zoladex				
<input type="radio"/> Eligard				
<input type="radio"/> Trelstar				
<input type="radio"/> Emcyt	<input type="radio"/> 140mg			
<input type="radio"/> Xgeva	<input type="radio"/> 120mg			
<input type="radio"/> Other				

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