PROSTATE CANCER REFERRAL FORM

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Diagnosis/Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

Primary Diagnosis: _____ Date of diagnosis: _____

Prior Therapy: ☐ No ☐ Yes (provide details): _____

_____

Comorbidities: _____

Concomitant medications: _____

Additional Information

Today's Date	Delivery Date	Deliver to: ☐ Home ☐ Prescriber	Special Instructions

Prescription Information

MEDICATION	DIRECTIONS FOR USE	QTY	REFILLS
☐ **Erleada®**	☐ Take 240mg by mouth once daily with a full glass of water ☐ _____	☐ 120 x 60mg tablets ☐ _____	
☐ **Xtandi®**	☐ Take 160mg by mouth once daily ☐ _____	☐ 120 x 40mg capsules ☐ _____	
☐ **Zytiga®**	☐ Take 1,000mg by mouth once daily on an empty stomach ☐ _____	☐ 120 x 250mg tablets ☐ 60 x 500mg tablets ☐ _____	
	Patient will be obtaining Prednisone at ☐ Amber Pharmacy ☐ Other ☐ Not receiving (state reason): _____		
☐ **Prednisone®**	☐ Take 5mg by mouth twice daily with food ☐ Take 5mg by mouth once daily with food	☐ 60 x 5mg tablets ☐ 30 x 5mg tablets	
☐ **Yonsa®**	☐ Take four tablets (500mg) by mouth once daily with or without food.	☐ 120 x 125mg tablets	
	Patient will be obtaining Methylprednisolone at ☐ Amber Pharmacy ☐ Other ☐ Not receiving (state reason): _____		
☐ **Methylprednisolone**	☐ Take 4mg by mouth twice daily with food. ☐ _____	☐ 60 x 4mg tablets ☐ _____	
ADJUNCT THERAPY OPTIONS	DIRECTIONS FOR USE	QTY	REFILLS
☐ **Casodex®** ☐ **Eulexin®** ☐ **Nilandron®**			
☐ **Trelstar®** ☐ **Vantas®** ☐ **Zoladex®** ☐ **Lupron Depot®**			
☐ **Firmagon®**			

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)