

# PROSTATE CANCER REFERRAL FORM

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



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Prescriber NPI			
Sex	Male	Female	Weight (kg)		Height (ft,in)	Nurse/Key Contact		Phone/Pager	
Insurance Plan			Plan ID #			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
Ereleada®	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. Patient will be obtaining Methylprednisolone at Amber Pharmacy Other Not receiving (state reason): _____	120 x 125mg tablets	
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) \_\_\_\_\_

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