

PROSTATE CANCER CARE PROGRAM

1 PATIENT INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Alt. Phone: _____
 Email: _____
 DOB: _____ Gender: M F Caregiver: _____
 Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 NPI: _____ DEA: _____
 Tax I.D.: _____
 Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ Diagnosis: C61: Malignant Neoplasm of Prostate R97.2: Elevated PSA Other: _____ Start Date: _____
 Weight: _____ lb kg Height: _____ in cm BSA: _____ m²

Prior Failed Therapies:

1. _____ 4. _____ PSA Antigen Level: _____ Date: _____
 2. _____ 5. _____ Gleason Score: _____ Date: _____
 3. _____ 6. _____ Digital Rectal Exam (DRE): Yes No Date: _____
 Reason for Discontinuation: _____ Biopsy of MRI: Yes No Date: _____
 Prostate Cancer Stage: _____ Has patient undergone
 Date: _____ (removal of testicles)? Yes No Date: _____

Required Lab Values/Test:

Duration of Treatment: As clinically warranted
 Until Disease Progression Other: _____

Is patient an eligible surgical candidate? Yes No
 If no, please explain: _____

Disease Characteristics: Advanced Metastatic
 Unresectable Castration-resistant
 Castration-sensitive

Adjunctive Therapies: Antiandrogen Radiotherapy
 Methylprednisolone Luteinizing hormone-releasing
 hormone agonist (LHRH) Chemical castration
 Gonadotropin-releasing hormone analog

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> ABIRATERONE (ZYTIGA)	Zytiga: <input type="checkbox"/> 250mg, <input type="checkbox"/> 500mg tablets Micronized formulation (Yonsa): 500 mg tablets	<input type="checkbox"/> Zytiga: Take 1,000mg by mouth once daily <input type="checkbox"/> Yonsa: Take 500 mg by mouth once daily		
<input type="checkbox"/> APALUTAMIDE (ERLEADA)	<input type="checkbox"/> 60mg tablets	<input type="checkbox"/> Take 3 tablets (240 mg) by mouth once daily		
<input type="checkbox"/> BICALUTAIDE (CASODEX)	<input type="checkbox"/> 50mg tablets	<input type="checkbox"/> Take 3 tablets (240 mg) by mouth once daily		
<input type="checkbox"/> DAROLUTAMIDE (NUBEQA)	<input type="checkbox"/> 300mg tablets	<input type="checkbox"/> Take 2 tablets (600 mg) by mouth twice daily		
<input type="checkbox"/> DEGARELIX (FIRMAGON)	Subcutaneous Solution: <input type="checkbox"/> 80mg <input type="checkbox"/> 120mg	<input type="checkbox"/> Loading dose: Inject 240 mg subcutaneously as two 120 mg SQ injections <input type="checkbox"/> Maintenance dose: Inject 80 mg subcutaneously every 28 days (beginning 28 days after loading dose)		
<input type="checkbox"/> ENZALUTAMIDE (XTANDI)	<input type="checkbox"/> 40mg capsules	<input type="checkbox"/> Take 4 capsules (160 mg) by mouth once daily		
<input type="checkbox"/> FLUTAMIDE (EULEXIN)	<input type="checkbox"/> 125mg tablets	<input type="checkbox"/> Take 2 tablets (250 mg) by mouth three times daily (every 8 hours)		
<input type="checkbox"/> GOSERELIN (ZOLADEX)	Subcutaneous Implant: <input type="checkbox"/> 28-day implant: 3.6mg <input type="checkbox"/> 12-week implant: 10.8mg	Prostate cancer, advanced: <input type="checkbox"/> 28-day implant: 3.6 mg every 28 days. <input type="checkbox"/> 12-week implant: 10.8 mg every 12 weeks. Prostate cancer, Stage B2 to C: <input type="checkbox"/> Combination 28-day/12-week implant: 3.6mg implant, followed in 28 days by 10.8mg implant. <input type="checkbox"/> 28-day implant (alternate dosing): 3.6mg; repeated every 28 days for a total of 4 doses.		
<input type="checkbox"/> HISTRELIN (VANTAS)	Subcutaneous Implant: <input type="checkbox"/> 50 mg	<input type="checkbox"/> SubQ: 50 mg implant surgically inserted every 12 months.		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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<input type="checkbox"/> LEUPROLIDE (LUPRON)	Intramuscular (IM): <input type="checkbox"/> 7.5mg, <input type="checkbox"/> 22.5mg, <input type="checkbox"/> 30 mg, <input type="checkbox"/> 45mg Subcutaneous (SubQ) Eligard : <input type="checkbox"/> 7.5mg, <input type="checkbox"/> 22.5mg, <input type="checkbox"/> 30mg, <input type="checkbox"/> 45mg Subcutaneous (SubQ) Leuprolide acetate: <input type="checkbox"/> 1mg/0.2ml (5mg/ml) solution *Depot formulations are not interchangeable due to different release characteristics*	IM: <input type="checkbox"/> Lupron Depot 7.5mg (monthly): Inject 7.5 mg every month <input type="checkbox"/> Lupron Depot 22.5mg (3 month): Inject 22.5 mg every 12 weeks <input type="checkbox"/> Lupron Depot 30mg (4 month): Inject 30mg every 16 weeks <input type="checkbox"/> Lupron Depot 45mg (6 month): Inject 45mg every 24 weeks SubQ Eligard: <input type="checkbox"/> Inject 7.5mg monthly <input type="checkbox"/> Inject 22.5mg every 3 months <input type="checkbox"/> Inject 30mg every 4 months <input type="checkbox"/> Inject 45mg every 6 month SubQ Leuprolide acetate: <input type="checkbox"/> Inject 1mg daily		
<input type="checkbox"/> RELUGOLIX (ORGOVYX)	<input type="checkbox"/> 120mg tablets	<input type="checkbox"/> Take 3 tablets (360mg) by mouth on day 1, followed by 1 tablet (120mg) once daily thereafter		
<input type="checkbox"/> NILUTAMIDE (NILANDRON)	<input type="checkbox"/> 150 mg tablets	<input type="checkbox"/> Take 2 tablets (300 mg) by mouth once daily (starting the same day or day after surgical castration) for 30 days, followed by 150 mg once daily		
<input type="checkbox"/> TRIPTORELIN (TRELSTAR)	Trelstar: <input type="checkbox"/> 3.75mg <input type="checkbox"/> 11.25mg Trelstar Mixject: <input type="checkbox"/> 3.75mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 22.5mg Trelstar Mixject [preservative free]: <input type="checkbox"/> 3.75mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 22.5mg Triptodur (ER): <input type="checkbox"/> 22.5mg	<input type="checkbox"/> Inject 3.75mg IM once every 4 weeks <input type="checkbox"/> Inject 11.25mg IM once every 12 weeks <input type="checkbox"/> Inject 22.5mg IM once every 24 weeks		
<input type="checkbox"/> OTHER				
Supportive Medications		Dosage & Direction	QTY	Refills
<input type="checkbox"/> Budesonide® 9mg	<input type="checkbox"/> Emend®	<input type="checkbox"/> Neulasta®	<input type="checkbox"/> Zofran® 4mg	
<input type="checkbox"/> Colestipol® 2g	<input type="checkbox"/> Loperamide® 4mg	<input type="checkbox"/> Neupogen®		
<input type="checkbox"/> Decadron®	<input type="checkbox"/> Lovenox®	<input type="checkbox"/> Procrit®		

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