

Deliver to: Patient's Home Prescriber's Office Other: _____ Hold shipment until notified by prescriber Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work/Mobile Phone: _____
 First Name: _____ Home Address: _____
 S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____
 Guardian/Caregiver: _____ Sex: Male Female Height: _____ Weight: _____ lbs. kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____
 Subscriber Name: _____ Policy #: _____ BIN/PCN: _____
 Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ MD DO NP PA License #: _____ NPI #: _____ DEA #: _____
 Practice Name: _____ Phone: _____ Fax: _____
 Address: _____ Office Contact: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Secondary ICD-10: _____ Meds Tried & Failed: _____
 Allergies: _____ Concurrent Medications: _____
 Vaccination History: _____

5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
AFINITOR®	<input type="checkbox"/> 2.5 mg tab <input type="checkbox"/> 5 mg tab <input type="checkbox"/> 7.5 mg tab <input type="checkbox"/> 10 mg tab			
ELIGARD®	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg	• Inject _____ mg SC every _____ month(s)		
ERLEADA™	<input type="checkbox"/> 60 mg tab	• Take 4 tablets (240mg) PO QD with or without food		
GLEEVEC®	<input type="checkbox"/> 100 mg tab <input type="checkbox"/> 400 mg tab			
LUPRON DEPOT®	PFS: <input type="checkbox"/> 7.5 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg			
NEXAVAR®	<input type="checkbox"/> 200 mg tab	• Take 2 tablets (400mg) PO BID at least 1 hour before or 2 hours after eating		
NILANDRON®	<input type="checkbox"/> 150 mg tab	• Take 300 mg PO QD for 30 days, and then 150 mg PO QD		
NUBEQA®	<input type="checkbox"/> 300 mg tab	• Take 2 tablets (600 mg) PO BID with food		
SUTENT®	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 37.5 mg <input type="checkbox"/> 50 mg			
TRELSTAR®	<input type="checkbox"/> 3.75 mg Depo <input type="checkbox"/> 11.25 mg LA <input type="checkbox"/> 22.5 mg			
XIAFLEX®	<input type="checkbox"/> 0.9 mg SDV <input type="checkbox"/> (4) syringes for reconstitution & admin	• Inject 0.58 mg into plaque of flaccid penis for 2 injections, 1-3 days apart		
XTANDI®	<input type="checkbox"/> 40 mg caps	• Take 160 mg PO QD		
ZOLADEX®	<input type="checkbox"/> 3.6 mg <input type="checkbox"/> 10.8 mg			
ZYTIGA®	<input type="checkbox"/> 250 mg tab			

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ **PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.** Date ____ / ____ / ____