

**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: \_\_\_\_\_  lb  kg

### 2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and 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 and 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 tabs <input type="checkbox"/> 5 mg tabs <input type="checkbox"/> 7.5 mg tabs <input type="checkbox"/> 10 mg tabs			
ELIGARD®	<input type="checkbox"/> 7.5 mg kit <input type="checkbox"/> 22.5 mg kit <input type="checkbox"/> 30 mg kit <input type="checkbox"/> 45 mg kit	• Inject _____ mg SC every _____ month(s)		
EMCYT®	<input type="checkbox"/> 140 mg caps			
ERLEADA®	<input type="checkbox"/> 60 mg tabs	• Take 4 tablets (240 mg) PO QD with or without food		
FIRMAGON®	<input type="checkbox"/> 80 mg kit <input type="checkbox"/> 240 mg kit			
GLEEVEC®	<input type="checkbox"/> 100 mg tabs <input type="checkbox"/> 400 mg tabs			
JEVTANA™	<input type="checkbox"/> 60 mg kit	• Take 4 tablets (240 mg) PO QD with or without food		
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 tabs	• Take 2 tablets (400 mg) PO BID at least 1 hour before or 2 hours after eating		
NILANDRON®	<input type="checkbox"/> 150 mg tabs	• Take 300 mg PO QD for 30 days, and then 150 mg PO QD		
NUBEQA®	<input type="checkbox"/> 300 mg tabs	• Take 2 tablets (600 mg) PO BID with food		
ORGOVYX™	<input type="checkbox"/> 120 mg tabs	<input type="checkbox"/> Initial Dose: Take 3 tablets (360 mg) PO on the first day and then take 1 tablet (120mg) PO QD thereafter <input type="checkbox"/> Maintenance Dose: Take 1 tablet (120 mg) PO QD	30 30	0
SUTENT®	<input type="checkbox"/> 12.5 mg caps <input type="checkbox"/> 25 mg caps <input type="checkbox"/> 37.5 mg caps <input type="checkbox"/> 50 mg caps			
TRELSTAR®	<input type="checkbox"/> 3.75 mg kit <input type="checkbox"/> 11.25 mg kit <input type="checkbox"/> 22.5 mg kit			
VANTAS®	<input type="checkbox"/> 50 mg kit			
XGEVA®	<input type="checkbox"/> 120 mg SDV			
XIAFLEX®	<input type="checkbox"/> 0.9 mg SDV <input type="checkbox"/> 4 syringes	• Inject 0.58 mg into plaque of flaccid penis for 2 injections, 1-3 days apart		
XTANDI®	<input type="checkbox"/> 40 mg caps <input type="checkbox"/> 40 mg tabs <input type="checkbox"/> 80 mg tabs	• Take 160 mg PO QD		
YONSA	<input type="checkbox"/> 125 mg tablet	• Take 4 tablets (500 mg) PO QD in combination with methylprednisolone		
ZOLADEX®	PFS: <input type="checkbox"/> 3.6 mg <input type="checkbox"/> 10.8 mg			
ZYTIGA®	<input type="checkbox"/> 250 mg tabs <input type="checkbox"/> 500 mg tabs			

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

**Account Manager**

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_

### 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_