PROSTATE CANCER CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**

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: ______m^2

Prior Failed Therapies:

1. ______ 4. ______
2. ______ 5. ______
3. ______ 6. ______

Reason for Discontinuation:

Prostate Cancer Stage: ______

Date:______

Required Lab Values/Test:

PSA Antigen Level: ______ Date: ______
Gleason Score: ______ Date: ______
Digital Rectral Exam (DRE): ❑ Yes ❑ No Date: ______
Biopsy of MRI: ❑ Yes ❑ No Date: ______
Has patient undergone bilateral orchiectomy (removal of testicles)? ❑ Yes ❑ No Date: ______

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

Signature: ______ Date: ______
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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PRESCRIPTION INFORMATION:

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

Medication	Dosage & Strength	Direction	QTY	Refills
❑ LEUPROLIDE (LUPRON)	Intramuscular (IM): ❑ 7.5mg, ❑ 22.5mg, ❑ 30 mg, ❑ 45mg Subcutaneous (SubQ) Eligard : ❑ 7.5mg, ❑ 22.5mg, ❑ 30mg, ❑ 45mg Subcutaneous (SubQ) Leuprolide acetate: ❑ 1mg/0.2ml (5mg/ml) solution *Depot formulations are not interchangable due to different release characterisitcs*	**IM:** ❑ Lupron Depot 7.5mg (monthly): Inject 7.5 mg every month ❑ Lupron Depot 22.5mg (3 month): Inject 22.5 mg every 12 weeks ❑ Lupron Depot 30mg (4 month): Inject 30mg every 16 weeks ❑ Lupron Depot 45mg (6 month): Inject 45mg every 24 weeks **SubQ Eligard:** ❑ Inject 7.5mg monthly ❑ Inject 22.5mg every 3 months ❑ Inject 30mg every 4 months ❑ Inject 45mg every 6 month **SubQ Leuprolide acetate:** ❑ Inject 1mg daily		
❑ RELUGOLIX (ORGOVYX)	❑ 120mg tablets	❑ Take 3 tablets (360mg) by mouth on day 1, followed by 1 tablet (120mg) once daily thereafter		
❑ NILUTAMIDE (NILANDRON)	❑ 150 mg tablets	❑ 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		
❑ TRIPTORELIN (TRELSTAR)	Trelstar: ❑ 3.75mg ❑ 11.25mg Trelstar Mixject: ❑ 3.75mg ❑ 11.25mg ❑ 22.5mg Trelstar Mixject [preservative free]: ❑ 3.75mg ❑ 11.25mg ❑ 22.5mg Triptodur (ER): ❑ 22.5mg	❑ Inject 3.75mg IM once every 4 weeks ❑ Inject 11.25mg IM once every 12 weeks ❑ Inject 22.5mg IM once every 24 weeks		
❑ OTHER				

Supportive Medications	Dosage & Direction	QTY	Refills
❑ Budesonide® 9mg ❑ Colestipol® 2g ❑ Decadron® ❑ Emend® ❑ Loperamide® 4mg ❑ Lovenox® ❑ Neulasta® ❑ Neupogen® ❑ Procrit® ❑ Zofran® 4mg			

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