Biologics

McKesson Specialty Health

Prostate Cancer Prescription Referral Form

Fax: 800.823.4506 Phone: 800.850.4306, option 2

To ensure your patient receives his/her medication as soon as possible, please complete and fax this form, with the patient's relevant treatment history and clinic notes to support the prior authorization process.

☐ **Contact Prescriber with results of benefits investigation before initiating dispense or contacting patient.**

PATIENT INFORMATION

Full Name__________ Gender ☐ M ☐ F DOB__________ Social Security #__________

Shipping Address__________ City__________ State__________ Zip__________

Home Phone__________ Alternate Phone__________

Alternate Contact__________ Relationship__________

Alternate Contact Phone__________ **Oncology Care Model Patient** ☐ YES ☐ NO

INSURANCE INFORMATION

Please include a copy of the front and back of the patient's medical and prescription insurance cards.

CLINICAL INFORMATION

ICD-10 Code__________ Primary Diagnosis/Stage__________

Height__________ Weight__________ Allergies__________

Prior Therapies__________

Reasons for Discontinuation__________ Year__________

Is patient receiving oral steroids? ☐ YES ☐ NO If yes, give dose/duration: Prednisone__________ Dexamethasone__________

Notes__________

List other medications that are being administered as part of this chemotherapy regimen including dose and duration.

PRESCRIBER INFORMATION

Hospital/Clinic__________ Office Contact__________

Address__________ City__________ State__________ Zip__________

Phone__________ Fax__________ Tax ID__________

Prescriber Names	DEA #	NPI #
☐		
☐		
☐		
☐		
☐		

PRESCRIPTION INFORMATION

Rx Start Date__________ **Rx Sent Via** ☐ fax ☐ escribe

☐ **ZYTIGA® (abiraterone acetate) 1000 mg daily**
250 mg tablets #120
Sig: take 4 tablets by mouth once daily
Refills__________

☐ **Prednisone 5 mg twice daily**
5 mg tablets #60
Sig: take 1 tablet by mouth twice daily
Refills__________

☐ **XTANDI® (enzalutamide) 160 mg daily**
40 mg capsules #120
Sig: take 4 capsules by mouth once daily
Refills__________

☐ **Other:**__________
#:__________ Refills__________
Sig:__________

ZYTIGA® (abiraterone acetate)

Indication: ZYTIGA is a CYP17 inhibitor indicated in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer.

Dosage: ZYTIGA 1,000 mg orally once daily in combination with prednisone 5 mg orally twice daily. Zytiga must be taken on an empty stomach. No food should be consumed for at least two hours before or one hour after Zytiga is taken. The tablets should be swallowed whole with water. Do not crush or chew.

Form: Tablet 250 mg

XTANDI® (enzalutamide)

Indication: XTANDI is an androgen receptor inhibitor indicated for the treatment of patients with metastatic castration-resistant prostate cancer.

Dosage: XTANDI 160 mg administered orally once daily. Xtandi can be taken with or without food. Swallow capsules whole.

Form: Capsule 40 mg

Prescriber Signature (No Stamps)__________ **Date**__________

Please attach a separate prescription if this form does not comply with your state's prescription law.

OPSG.4.0.110716

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