

PATIENT INFORMATION

Patients Name:		SSN#:		DOB:	
Address:		City:		State:	
Home Phone:		Cell Phone:		Height:	
				Weight:	
Email Address:				Gender: Male Female	
				Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

PRESCRIPTION INFORMATION (For IV medications attach a copy of your prescription.)

To prevent generic substitution, Prescriber to handwrite "Brand Medically Necessary" and sign: _____

ZYTIGA® (abiraterone)

- 250mg tablet 500mg tablet

Directions:

- Take 1,000 mg (FOUR 250 mg tablets) once daily by mouth on an empty stomach
 Take 1,000 mg (TWO 500 mg tablets) once daily by mouth on an empty stomach

Qty: _____ Refills: _____

PREDNISONE

- CRPC:** Take 5mg by mouth twice daily with food
 CSPC: Take 5mg by mouth daily with food

Qty: _____ Refills: _____

ERLEADA™ (apalutamide)

- 60mg tablet

Directions:

- Take 240mg (FOUR 60mg tablets) once daily

Qty: _____ Refills: _____

YONSA® (abiraterone)

- 125mg tablet

Directions:

- Take 500mg (FOUR 125mg tablets) by mouth once daily

Qty: _____ Refills: _____

METHYLPREDNISOLONE

- Take 4mg by mouth twice daily with food

Qty: _____ Refills: _____

***If patient has not had a bilateral orchiectomy or currently on gonadotropin-releasing hormone (GnRH) analog therapy, prescribe below in "Other." ***

LHRH Agonists:

- TRELSTAR® (triptorelin)
 ZOLADEX® (goserelin)
 VANTAS® (histrelin)
 ELIGARD® (leuprolide)
 LUPRON DEPOT® (leuprolide)

1st Generation Antiandrogens:

- NILANDRON® (nilutamide)
 EULEXIN® (flutamide)
 CASODEX® (bicalutamide)

Please use this section for additional directions or other medications not listed.

- OTHER

STRENGTH:

SIG/DIRECTIONS

QUANTITY:

Start of Therapy Date:

REFILLS:

Special Delivery Instructions:

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact/Faxed By:		Email:			
NPI#:		TAX ID#:		Ship To: <input type="checkbox"/> Patient <input type="checkbox"/> MD Office 1st Order Only <input type="checkbox"/> MD Office All Orders	
Prescriber Signature		Date:			
<input type="checkbox"/> Dispense as written					

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.

RxExpress 2-Day Ready 2 Ship:
Receive all the benefits of our fast and easy express service, including our NEW 2-Day Ready 2 Ship, for all eligible prescriptions.

BioPlus Specialty Pharmacy
376 Northlake Blvd., Altamonte Spings, FL 32701

RxExpress
2-Day Ready 2 Ship

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