BioPlus® Specialty Pharmacy
A CAREPATHrx Company

E-prescribe the *Fast & Easy* way: select **BioPlus Specialty Pharmacy** from your EHR!

Urology Referral Form

Fax: 800-269-5493
Phone: 833-ONC-EASY (662-3279)
bioplusrx.com

PATIENT INFORMATION

Patient Name:		SSN:	DOB:
Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Height:	Weight: Gender: ☐ Male ☐ Female
Email Address:		Diagnosis Code:	

INSURANCE INFORMATION (or attach copy of cards)

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

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Abiraterone *(generic for Zytiga)*
☐ 250 mg tablet ☐ 500 mg tablet
Directions:
☐ Take 1000 mg once daily by mouth on an empty stomach
☐ Other: _____
Qty: Refills:

PREDNISONE
☐ CRPC: Take 5 mg by mouth twice daily with food
☐ CSPC: Take 5 mg by mouth once daily with food
Qty: Refills:

XTANDI® *(enzalutamide)*
☐ 40 mg tablets ☐ 40 mg capsule
☐ 80 mg tablets ☐ 80 mg capusles
Directions:
☐ 160 mg (FOUR 40 mg capsules or TWO 80 mg tablets) administered orally once daily.
Qty: Refills:

ERLEADA™ *(apalutamide)* ☐ 60 mg tablet
Directions:
☐ Take 240 mg (FOUR 60 mg tablets) once daily
Qty: Refills:

YONSA® *(abiraterone)* ☐ 125 mg tablet
Directions:
☐ Take 500 mg (FOUR 125 mg tablets) by mouth once daily
Qty: Refills:

METHYLPREDNISOLONE
☐ Take 4 mg 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:	REFILLS:
Start of Therapy Date:	Special Delivery Instructions:

Start of Therapy Date:

Ship To:
☐ Patient ☐ MD Office 1st Order Only ☐ MD Office All Orders

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.

☐ Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID #	
Prescriber Signature:	Date	

Your signature authorizes BioPlus Specialty Pharmacy Services,LLC, and their network of pharmacies, MedScripts Medical Pharmacy, River Medical Pharmacy, and Route 300 Pharmacy (the "BioPlus Pharmacies"), 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.

BioPlus Specialty Pharmacy 376 Northlake Blvd., Altamonte Springs, FL 32701 **BioPlus Specialty Pharmacy** 100 Southcenter Ct. Suite 100, Morrisville, NC 27560
BioPlus Specialty Pharmacy 13925 Yale Ave Ste 145 Irvine, CA 92620 **MedScripts Medical Pharmacy** 1325 Miller Rd. Suite K, Greenville, SC 29607
River Medical Pharmacy 4752 Research Drive, San Antonio, TX 78240 **Route 300 Pharmacy** 1208 Route 300 Suite 103, Newburgh, NY 12550

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