Ochsner Specialty Pharmacy

Oncology Urology

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Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other:__________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date:__________

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:__________ ☐ lbs. ☐kg.

Patient Insurance Information

(Please fax FRONT and BACK copy of ALL insurance cards prescription & medical)

Medical Insurance:__________ Phone:__________ Prescription Card: __________ Phone:__________
Subscriber Name:__________ Policy #:__________ BIN/PCN:__________
Policy #:__________ Group #:__________ Medicare #:__________ Medicaid #:__________

Prescriber Information

Prescriber Name:__________ ☐ ☐ ☐ ☐ License #:__________ NPI #:__________ DEA #:__________
Practice Name: __________ Phone:__________ Fax:__________
Address:__________ Office Contact:__________ Phone:__________
City: __________ State:__________ Zip:__________ Collaborating Physician:__________

Diagnosis/Clinical Information

(Please fax recent clinical notes, labs, and tests, with the prescription to expedite the prior authorization)

Primary ICD-10 Diagnosis:__________ Meds Tried & Failed:__________
Secondary ICD-10 Diagnosis:__________
Allergies:__________ Current Medications:__________
Vaccination History:__________

Prescription Information

Medication	Dose/Strength	Directions	Quantity	Refill
☐ Afinitor®	☐ 2.5mg tab ☐ 5mg tab ☐ 7.5mg tab ☐ 10mg tab			
☐ Eligard®	☐ 7.5mg ☐ 22.5mg ☐ 30mg ☐ 45mg	Inject________mg SC every ________ month(s)		
☐ Gleevec®	☐ 100mg tab ☐ FCT 400mg tab			
☐ Lupron Depot®	☐ 7.5mg PFS ☐ 11.25mg PFS ☐ 22.5mg PFS ☐ 30mg PFS ☐ 45mg			
☐ Lupron Depot-Ped®	☐ 7.5mg ☐ 11.25mg ☐ 15mg ☐ 30mg			
☐ Nexavar®	☐ 200mg tab	☐ Take 2 tablets (400mg) PO BID without food at least 1 hour before or 2 hours after eating. ☐ Other:__________		
☐ Nilandron®	☐ 150mg tab	Take 300mg PO QD for 30 days, and then 150mg PO QD.		
☐ Prolia®	☐ 60mg /1mL PFS	Inject 60mg SC every 6 months in the upper arm, upper thigh or abdomen		
☐ Casodex®	☐ 50mg tab	Take 150 mg (3 tablets)po once daily		
☐ Trelstar®	☐ 3.75mg Depo ☐ 11.25mg LA ☐ 22.5mg			
☐ Xgeva®	☐ 120mg/1.7mL SDV			
☐ Xiaflex®	☐ 0.9mg SDV ☐ Syringes for reconstitution & administration (Qty 4)	Inject 0.58 mg into plaque of flaccid penis for 2 injections, 1 to 3 days apart		
☐ Xtandi®	☐ 40mg caps	Take 160mg PO QD		
☐ Zoladex®	☐ 3.6mg ☐ 10.8mg			
☐ Zytiga®	☐ 250mg tab			
☐ Other:				

By signing this form and using our services, you are authorizing Ochsner Specialty Pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies. Prescriber signature below: (Provider attests that this is his/her legal signature **NO STAMPS)**

Prescriber Signature-Substitution Allowed **Date** **Prescriber Signature-Dispense as Written** **Date**