



Patient information **Prescriber + shipping information**

Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID # _____ Please fax a copy of front and back of the insurance card(s).	Physician Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to physician: <input type="checkbox"/> 1st Month <input type="checkbox"/> Always <input type="checkbox"/> Never
--	--

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10: _____ Any prior treatment: No Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____

Prescription

<input type="checkbox"/> Casodex®	Take one 50 mg tablet by mouth once daily Qty: 30 tablets	Refill: _____
<input type="checkbox"/> Lupron Depot®	Inject 1 PFS intramuscularly <input type="checkbox"/> 7.5 mg once every month <input type="checkbox"/> 22.5 mg once every 3 months <input type="checkbox"/> 30 mg once every 4 months <input type="checkbox"/> 45 mg once every 6 months Qty: 1 kit	Refill: _____
<input type="checkbox"/> Xtandi®	Take four 40 mg capsules by mouth once daily Qty: 120 capsules	Refill: _____
<input type="checkbox"/> Zytiga® with prednisone	Take four 250 mg tablets once daily without food Qty: 120 tablets Take one 5 mg tablet twice daily with food Qty: 60 tablets	Refill: _____ Refill: _____
<input type="checkbox"/> _____	Strength: _____ Qty: _____ Directions: _____	Refill: _____

Support Medications

<input type="checkbox"/> Aranesp® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Caphosol® <input type="checkbox"/> Emend® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Neulasta®	<input type="checkbox"/> Neupogen® <input type="checkbox"/> Nplate® <input type="checkbox"/> Procrit® <input type="checkbox"/> Promacta® <input type="checkbox"/> Sancuso® <input type="checkbox"/> Zofran®	Strength: _____ Quantity: _____ Directions: _____ _____ _____ Refill: _____ Packaging: <input type="checkbox"/> Normal *Call for ordering procedure
--	--	---

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature: _____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling (305) 221-1421 or by emailing pharmacy@rxpharmacy.com to obtain instructions as to the proper destruction of the transmitted material. Thank you.