Publix Specialty Pharmacy #3213

ORAL ONCOLOGY: PROSTATE CANCER

1950 Sand Lake Road, Bldg 5
Orlando, FL 32809
Phone: 855-797-8254
Fax: 863-413-5723

Patient Information [Attach copy of front and back of prescription insurance card(s)]

Patient's First Name: ______________________ Patient's Last Name: ______________________

Date of Birth: _____/_____/________ ☐ Male ☐ Female Caregiver Name: ______________________

Address: ______________________ City: __________ State: __________ Zip: __________

Primary Phone Number: (_____) ______________________ Alt. Phone Number: (_____) ______________________

Clinical Information: [Attach copy of labs and clinical notes] ☐ Urgent Request Using Cover My Meds: ☐ No ☐ Yes

Diagnosis code: ___________ Diagnosis: ☐ Prostate Cancer ☐ Other: ______________________

Treatment status: ☐ New to therapy ☐ Continuation of therapy, start date: ______/______/________ Weight: ______ ☐ kg ☐ lb

Advanced/metastatic disease: ☐ Yes ☐ No Height: ______ ☐ cm ☐ in

Prior therapies, treatment dates, and reason for discontinuation: ______________________

Other pertinent past medical history and/or drug therapy: ______________________

Allergies: ☐ NKDA ☐ Other: ______________________

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY/DAYS	REFILLS
☐ Erleada (apalutamide)	60 mg tablet	☐ Take 240 mg (4 tabs) PO one time daily ☐ Other: ______________________	30 days	_______
☐ Yonsa (abiraterone)	125 mg tablet	☐ Take 500 mg (4 tabs) PO one time daily ☐ Other: ______________________	30 days	
Include: ☐ Methylprednisolone	4 mg tablet	☐ Take 1 tab PO twice a day with food ☐ Other: ______________________		_______
☐ Zytiga (abiraterone)	☐ 500 mg tablet ☐ 250 mg tablet	Take 1,000 mg PO one time daily at least 1 hour before and 2 hours after meal Other: ______________________	30 days	
Include: ☐ Prednisone	5 mg tablet	☐ Take 1 tab PO twice a day with food ☐ Other: ______________________		_______
☐ __________	__________	______________________	_______	_______
☐ __________	__________	______________________	_______	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only Appointment date: ______/______/__________

Name: ______________________ DEA# ______________ NPI # ______________

Supervising Physician: ☐ Not Applicable ☐ ______________________ Supervising Physician NPI # ______________

Address: ______________________ City: __________ State: __________ Zip: __________

Office Phone Number: (_____) __________ Fax Number: (_____) __________ Office Contact: __________

I authorize Publix Pharmacy representatives to act on behalf of the prescriber to initiate and complete the insurance prior authorization process.

Prescriber's signature: (stamps not accepted)

______________________ ☐ Substitution allowed Date

______________________ ☐ Dispense as written/ Do not substitute Date

For states requiring hand written expressions to prevent substitution, write here:

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