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

Address: ____ City: _________________________ State: ________ Zip: __________

Primary Phone Number: (_____) ___________________ Alt. Phone Number: (_____) __________________ Caregiver name: __________________________

Clinical Information [Attach copy of labs and clinical notes]

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
☐ Casodex (bicalutamide)	50 mg tablet	Take 1 tab PO once daily with or without food	30 days	_______
☐ Emcyt (estramustine) Patient weight: ________	140 mg capsule	☐ Take ______ mg PO TID at least 1 hour before and 2 hours after meals ☐ Take ______ mg PO QID at least 1 hour before and 2 hours after meals ☐ Other: ______________________	30 days	_______
☐ Erleada (apalutamide)	60 mg tablet	☐ Take 240 mg (4 tabs) PO once daily ☐ Other: ______________________	30 days	_______
☐ Nilandron (nilutamide)	150 mg tablet	Initial Dose: ☐ Take 300 mg (2 tabs) PO once daily with or without food	30 days	0
		Maintenance Dose: ☐ Take 150 mg (1 tab) PO once daily with or without food	30 days	_______
☐ Yonsa (abiraterone)	125 mg tablet	☐ Take 500 mg (4 tabs) PO once daily with or without food ☐ Other: ______________________	30 days	_______
Include: ☐ Methylprednisolone	4 mg tablet	☐ Take 1 tab PO BID with food ☐ Other: ______________________		
☐ Zytiga (abiraterone)	☐ 500 mg tablet ☐ 250 mg tablet	☐ Take 1,000 mg PO once daily at least 1 hour before and 2 hours after meal ☐ Other: ______________________	30 days	_______
Include: ☐ Prednisone	5 mg tablet	☐ Take 1 tab PO BID with food ☐ Other: ______________________		
☐ Other: ________________	________________	______________________________________	__________	_______

Prescriber Information

Ship to prescriber: ☐ Never ☐ Always ☐ First fill only, appointment date: ___/___/_____ Using Cover My Meds: ☐ No ☐ Yes

Name: ____ DEA# _______________________ 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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(09-20)