Zarina Pharmacy
SPECIALTY & INFUSION

Skip this form & e-prescribe! Select BioPlus from your E

Fax: 832-886-4298
Phone: 832-886-4296
zarinapharmacy.com

UROLOGY

PATIENT INFORMATION

Name:		SSN:		DOB:
Address:		City:	State:	ZIP:
Home Phone:	Cell:	Height:	Weight:	Gender: ○ Female ○ Male
Email:		Diagnosis Code:		

INSURANCE INFORMATION (or attach copy of the cards)

Primary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance:	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION (for IV medication attach a copy of the prescription)

Abiraterone (generic for Zytiga)
☐ 250 mg tablet ☐ 500 mg tablet
Directions:
☐ Take 1,000 mg once daily PO on an empty stomach
☐ Other: _____
Qty: ☐ Refills: ☐

PREDNISONE ☐ Rx sent to local pharmacy
☐ CRPC: Take 5 mg PO twice daily with food
☐ CSPC: Take 5 mg PO once daily with food
Qty: ☐ Refills: ☐

XTANDI® (enzalutamide)
**** If no specific formulation is indicated, the pharmacy will dispense tablets****
☐ 40 mg tablets ☐ 40 mg capsule ☐ 80 mg tablet
Directions:
☐ 160 mg (FOUR 40 mg capsules or TWO 80 mg tablets) administered PO 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) PO once daily
Qty: ☐ Refills: ☐

METHYLPREDNISOLONE
☐ Rx sent to local pharmacy
☐ Take 4 mg PO 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." ***

LHR Agonist

☐ **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

Injection Training: ☐ Office to Instruct ☐ SP to Arrange Teaching

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