Express Health Mart Pharmacy
1173 Nostrand ave,
Brooklyn, NY 11225

Urology Oral Medications Enrollment Form

Tel: 347-221-1100
E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com
www.expresshealthmart.com

Date: _____ **Needs by Date:** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last Four of SS #: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____
Is the patient eligible for Medicare? ☐ Yes ☐ No

STATEMENT OF MEDICAL NECESSITY

Diagnosis Description: ☐ Prostate Cancer Diagnosis (ICD-9 code): ☐ 185 Date of Diagnosis: _____
Diagnosis Description: ☐ _____ Diagnosis (ICD-9 code): _____ Date of Diagnosis: _____

Other Clinical Information/Comments:

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ inches ☐ cm BSA: _____ m^2
Other Conditions: _____
Other Medications: _____
Allergies: _____ ☐ No Known Drug Allergy
Previous Therapies: ☐ Docetaxel
Other therapies: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG./DIRECTIONS	OTHER SIG./DIRECTIONS
☐ Zytiga	250mg	☐ 4 tablets po once daily #120	
☐ Prednisone	5mg	☐ 1 tablet po twice daily #60	
☐ Xtandi®	40mg	☐ 4 capsules po once daily #120	

Refills: Quantity:

☐ Please enroll my patient into the following manufacturer patient support program:

Physician's Signature

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)