

FAX FORM TO: 1.866.233.8317

PHONE: 1.855.492.0817

EMAIL: contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION	
Name:	
Address:	
City, State, ZIP:	
Primary Phone: - -	DOB: / /
Alternate Phone: - -	Gender:
Email:	
Primary Language:	Last Four of SSN:

2. PRESCRIBER INFORMATION		
Name:		
DEA #:	NPI #:	State Lic. #:
Group or Hospital:		
Address:		
City, State, Zip:		
Phone: - -	Fax: - -	
Contact Person:	Phone: - -	

3. INSURANCE INFORMATION		<i>Fax copy of prescription and insurance cards with this form, if available (front and back)</i>	
Primary Insurance Company Name:		Secondary Insurance Company Name:	
Primary Cardholder Name:		Secondary Cardholder Name:	
Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent		Relationship: <input type="radio"/> Self <input type="radio"/> Spouse/Partner <input type="radio"/> Child/Dependent	
Phone: - -	Member ID:	Group #:	

4. DIAGNOSIS AND CLINICAL INFORMATION			
Needs by Date: / /		Ship to: <input type="radio"/> Patient <input type="radio"/> Office <input type="radio"/> Other:	
Date of Diagnosis: / /		Previous Therapies: <input type="radio"/> Docetaxel <input type="radio"/> Other:	
<input type="radio"/> C61 Malignant neoplasm of the prostate		Allergies:	
<input type="radio"/> Other Diagnosis:		Other Conditions:	
Height (in/cm):	Weight (lb/kg):	Current Medications:	

5. PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="radio"/> Prednisone	5 mg	<input type="radio"/> Take 1 tablet by mouth twice daily. <input type="radio"/> Other:		
<input type="radio"/> Xtandi	40 mg	<input type="radio"/> Take 4 capsules once daily. <input type="radio"/> Other:		
<input type="radio"/> Zytiga	250 mg	<input type="radio"/> Take 4 tablets by mouth once daily. <input type="radio"/> Other:		
<input type="radio"/>				
<input type="radio"/>				
<input type="radio"/>				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE	
X _____ / /	X _____ / /
DISPENSE AS WRITTEN	PRODUCT SUBSTITUTION PERMITTED
DATE	DATE

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