

FAX FORM TO: 1.877.597.3070

PHONE: 1.800.473.3516

EMAIL: specialty@wellpartner.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 *Fax copy of prescription and insurance cards with this form, if available (front and back)*

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 #:	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	DATE	PRODUCT SUBSTITUTION PERMITTED	DATE

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