PUBLIX PHARMACY
Feeling well. Living better.

Oral Oncology Referral Form: Prostate Cancer
Publix Specialty Pharmacy (#3212)

7616 Southland Blvd, Suite 112
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 office 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, reason for discontinuation, treatment dates: _____

Other pertinent past medical history and/or drug therapy: _____

Allergies: ☐ NKDA ☐ Other: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS	DISPENSE QTY FOR	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	_____
☐ 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	_____
☐ Zytiga (abiraterone)	☐ 500 mg tablet ☐ 250 mg tablet	☐ Take 1,000 mg PO once daily at least 2 hours before and 1 hour 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: ___/___/_____] Use 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: