



Hormonal Therapies

Delivery Need By: _____ Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Other _____

PATIENT INFORMATION

Patient Name: _____ ☐ Male
Address: _____ ☐ Female
City: _____ State: _____ Zip: _____
Phone Number: _____
Email Address: _____
Last Four of Social: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
Office Contact Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____
DEA/NPA #: _____

INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: _____
ICD-10 Code: _____
Height: _____ ft _____ inches Weight: _____ lbs
Allergies: _____

Has the patient been treated previously for this condition?

☐ Yes ☐ No

Medications Failed: _____
Medications On: _____
Other Notes: _____

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Firmagon	<input type="checkbox"/> 120 mg vial <input type="checkbox"/> 80 mg vial	Initial Dose: <input type="checkbox"/> Inject 240mg (2-120mg injections) SC Maintenance Dose: <input type="checkbox"/> Inject 80 mg SC every 28 days	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other	
Lupaneta Pack (leuprolide, norethindrone)	<input type="checkbox"/> 3.75 mg suspension for injection, 5mg tablet <input type="checkbox"/> 11.25 mg suspension for injection, 5mg tablet	<input type="checkbox"/> 3.75mg IM once monthly, 5mg tablet by mouth once daily <input type="checkbox"/> 11.25mg IM once every 3 months, 5mg tablet by mouth once daily	<input type="checkbox"/> 1 pack <input type="checkbox"/> Other	
Lupron Depot	<input type="checkbox"/> 3.75 suspension for injection <input type="checkbox"/> 7.5mg suspension for injection <input type="checkbox"/> 11.25 mg suspension for injection <input type="checkbox"/> 22.5mg suspension for injection <input type="checkbox"/> 30mg suspension for injection <input type="checkbox"/> 45mg suspension for injection	<input type="checkbox"/> _____mg IM once monthly <input type="checkbox"/> _____mg IM once every 3 months <input type="checkbox"/> _____mg once every 4 months <input type="checkbox"/> _____mg once every 6 months	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other	
Supprelin LA	<input type="checkbox"/> 50 mg SC implant	<input type="checkbox"/> 1 implant inserted SC every 12 months	<input type="checkbox"/> 1 implant <input type="checkbox"/> Other	
Trelstar	<input type="checkbox"/> 3.75 mg suspension for injection <input type="checkbox"/> 11.25 mg suspension for injection <input type="checkbox"/> 22.5 mg suspension for injection	<input type="checkbox"/> _____mg IM once monthly <input type="checkbox"/> _____mg IM once every 3 months <input type="checkbox"/> _____mg once every 6 months	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other	
Vantas	<input type="checkbox"/> 50 mg SC implant	<input type="checkbox"/> 1 implant inserted SC every 12 months	<input type="checkbox"/> 1 implant <input type="checkbox"/> Other	
Zoladex	<input type="checkbox"/> 3.6 mg implant <input type="checkbox"/> 10.8 mg implant	<input type="checkbox"/> 3.6 mg subcutaneous into the upper abdominal wall every 28 days <input type="checkbox"/> 10.8 mg subcutaneous into the upper abdominal wall once every 12 weeks <input type="checkbox"/> Other	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other	
Other				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Physician Signature: _____ Date: _____