Eulexin™ (flutamide) 125mg capsules

PRESCRIPTION & ENROLLMENT FORM

☐ New patient ☐ Current patient

Note: This form is intended for prescriber use only.
If faxed, the fax must come from MD office or hospital
(should not be faxed by patient).

PATIENT INFORMATION (Include the front and back copy of the patient's insurance card)

Patient name _____ Date of birth _____ ☐ Male ☐ Female

Street address _____ City _____ State _____ Zip _____

Parent/guardian (if applicable) _____ ☐ Principle contact

Home phone _____ Work phone _____ Cell phone _____ Evening phone _____

E-mail address _____

Insurance company name _____ Insurance company phone # _____

Insured name _____ Insured employer _____

Relationship to patient _____ Identification # _____ Policy/group # _____

Prescription card ☐ No ☐ Yes If yes, carrier _____ Policy # _____ Group # _____

Eligible for Medicare? ☐ No ☐ Yes Eligible for Medicaid? ☐ No ☐ Yes

PRESCRIBER INFORMATION

Date _____ Time _____

Prescriber name _____ Prescriber practice title _____

Street address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

License # _____ DEA # _____ Physician Medicaid UPIN # _____ NPI# _____

MD specialty _____ For ARNP, NP, and PA, collaborative physician agreement with: _____

CLINICAL INFORMATION

ICD-10 code: _____ Secondary ICD-10: _____ Other _____

Other lab tests completed: _____ Date: _____

Patient weight: _____ ☐ NKDA ☐ Known drug allergies _____

PRESCRIBING INFORMATION

Eulexin (flutamide) 125mg capsules

☐ Recommended dosage: 250mg (2 capsules) by mouth three times a day at 8 hour intervals

☐ Other dosage: _____

Deliver product to: Patient home ☐ Yes ☐ No Other ☐ Yes ☐ No Ship to address: _____

EULEXIN QUICKSTART PROGRAM

If there is a delay in verifying insurance coverage, I authorize the Eulexin QuickStart Program pharmacy to dispense a free initial supply of Eulexin to eligible patients.
Terms and Conditions apply.

Eulexin (flutamide) 125mg capsules

Dosage: _____

Deliver product to: ☐ Patient home ☐ Other

Ship to address: _____

PRESCRIBER SIGNATURE

By signing below, I certify that the prescribed therapy is medically necessary.

Physician printed name _____

Physician signature _____ Date _____ (No stamps) (Dispense as written)

Physician signature _____ Date _____ (No stamps) (Substitutions permitted)

This prescription is valid only if transmitted by means of a facsimile machine directly from the prescriber's office or place of practice.

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. Drug names are the property of their respective owners.