

Tel: 1-888-398-0028 | Email: accesslink@bioscript.ca

Please fax completed form to: 1-855-278-5182 (Fax)

Patient Information

First Name: _____ Last Name: _____ DOB: (MM/DD/YYYY): _____
Phone: _____ Email: _____ Health Card #: _____

Best time for contact: Morning Afternoon Evening Can the AccessLink team leave you a message? Yes No

Authorized Representative (if applicable)

Name: _____ Address: _____
Phone: _____ City: _____
Email: _____ Prov: _____ Postal Code: _____

Indication and Prescription

ADT for Prostate Cancer

Eligard 7.5mg SC q1mth 22.5mg SC q3mth 30mg SC q4mth 45mg SC q6mth	Firmagon 240mg SC once (loading dose) 80mg SC q1mth thereafter	Lupron Depot 7.5mg IM q1mth 22.5mg IM q3mth 30mg IM q4mth	Trelstar 11.25mg IM q3mth 22.5mg IM q6mth	Zeulide Depot 3.75mg IM q1mth 22.5mg IM q3mth	Zoladex 3.6mg SC q1mth 10.8mg SC q3mth
Mitte: _____ days Refills: _____	Mitte: _____ days Refills: _____	Mitte: _____ days Refills: _____	Mitte: _____ days Refills: _____	Mitte: _____ days Refills: _____	Mitte: _____ days Refills: _____

Non-Metastatic Castration Resistant PSAdt < 10 months
Apalutamide 240mg PO once daily
Darolutamide 600mg PO twice daily
Enzalutamide 160mg PO once daily
Other: _____

Mitte: _____ days
Refills: _____

Metastatic Castration Sensitive
Abiraterone 1000mg PO once daily
+ Prednisone 5mg PO once daily
Apalutamide 240mg PO once daily
Darolutamide 600mg PO twice daily
Enzalutamide 160mg PO daily
Other: _____

Mitte: _____ days
Refills: _____

Metastatic Castration Resistant
Abiraterone 100mg PO once daily +
Prednisone 5mg PO once daily
Darolutamide 600mg PO twice daily
Enzalutamide 160mg PO once daily
Other: _____

Mitte: _____ days
Refills: _____

HRR mutations (BRCA1, BRCA2)
Niraparib 200mg PO once daily +
Abiraterone 1000mg PO once daily +
Prednisone 5mg PO once daily
Olaparib 300 PO twice daily +
Abiraterone 1000mg PO once daily +
Prednisone 5mg PO once daily

Other: _____
Mitte: _____ days
Refills: _____

Bone Health
High Fracture Risk
Denosumab 60mg SC q6 months
Calcium carbonate 1000mg PO
once daily
Vitamin D (high fracture risk) 1000IU
PO daily
Other: _____

Mitte: _____ days
Refills: _____

Bone Metastases Present
Denosumab 120mg SC q6 months
Mitte: _____ days
Refills: _____

Urinary Tract Symptoms
Botox 100 unit/vial
Injection by physician as directed.

Mitte: _____ days
Refills: _____

Notes:

Additional Services

First Injection Date (MM/DD/YY): _____

Delivery to :

Urgent
Prescriber's Clinic
Other _____

Patient Home
Alternate Address

Patient Consent and Signature

Patient has consented to being contacted by AccessLink for Drug Navigation Support.

Patient Signature: _____ Date (MM/DD/YY): _____

Verbal Consent Received by: _____

Prescriber Authorization

Prescriber Name (Printed): _____ Phone: _____ Fax: _____

Address and License #: _____

Prescriber Signature: _____ Date (MM/DD/YY): _____

Prescriber Certification

28052025

This prescription represents the original of the prescription drug order. The pharmacy address noted above is the only intended recipient and there are no others. The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.