



Urology Prescription Form

PATIENT INFORMATION You may also fax demographics/face sheet

Patient Name: _____ DOB: _____
 SSN: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____
 Known Allergies: _____
 Height: _____ Weight: _____ lbs. M F
 Emergency Contact: _____
 Emergency Contact Phone: _____

INSURANCE INFO. Please fax copy of ALL insurance cards *front & back

Primary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____
 Secondary Insurance: _____
 Policy Number: _____ Group Number: _____
 Rx Bin: _____ Rx PCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI#: _____ DEA#: _____ TAX ID: _____
 Address: _____ City, State, Zip: _____
 Office Contact: _____ Phone: _____ Fax: _____

DIAGNOSIS INFORMATION Please fax recent labs, clinical notes, etc. to help expedite the prior authorization process

Primary Diagnoses: _____ Primary ICD-10: _____ Secondary ICD-10: _____
 Prior Therapies: _____ Reasons for Discontinuation: _____
 Prior Therapies: _____ Reasons for Discontinuation: _____
 Comorbidities: _____ Known Allergies: _____

MEDICATIONS: You may tape Prescriptions here prior to faxing

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
<input type="checkbox"/> Abiraterone Acetate	<input type="checkbox"/> 250 mg tablets	<input type="checkbox"/> Take 1,000 mg orally once daily on an empty stomach <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Prednisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Bicalutamide	<input type="checkbox"/> 50 mg tablets	<input type="checkbox"/> Take 50 mg orally once daily <input type="checkbox"/> Take 150 mg orally once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Eligard® (leuprolide acetate)	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg	<input type="checkbox"/> Inject 7.5mg subcutaneously every month <input type="checkbox"/> Inject 22.5mg subcutaneously every 3 months <input type="checkbox"/> Inject 30mg subcutaneously every 4 months <input type="checkbox"/> Inject 45mg subcutaneously every 6 months		
<input type="checkbox"/> Erleada® (apalutamide)	<input type="checkbox"/> 60 mg tablets	<input type="checkbox"/> Take 240 mg orally once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Firmagon® (degarelix for injection)	<input type="checkbox"/> 120 mg/vial <input type="checkbox"/> 80 mg/vial	<input type="checkbox"/> Loading Dose: Inject two 120 mg injections subcutaneously <input type="checkbox"/> Maintenance Dose: Inject 80 mg injections subcutaneously every 28 days (initiate 28 days after loading dose) <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Flutamide	<input type="checkbox"/> 125 mg capsules	<input type="checkbox"/> Take 250 mg orally every 8 hours		
<input type="checkbox"/> Lupron Depot® (leuprolide acetate)	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 mg	<input type="checkbox"/> Inject 7.5 mg intramuscularly every month <input type="checkbox"/> Inject 22.5 mg intramuscularly every 3 months <input type="checkbox"/> Inject 30 mg intramuscularly every 4 months <input type="checkbox"/> Inject 45 mg intramuscularly every 6 months		
<input type="checkbox"/> Nubeqa® (darolutamide)	<input type="checkbox"/> 300 mg tablets	<input type="checkbox"/> Take 600 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Tice® BCG		<input type="checkbox"/> Instill 50 mg intravesically weekly for 6 weeks <input type="checkbox"/> Instill 50 mg intravesically every month		
<input type="checkbox"/> Trelstar® (triptorelin)	<input type="checkbox"/> 3.75 mg <input type="checkbox"/> 11.25 mg <input type="checkbox"/> 22.5 mg	<input type="checkbox"/> Inject 3.75 mg intramuscularly every month <input type="checkbox"/> Inject 11.25 mg intramuscularly every 3 months <input type="checkbox"/> Inject 22.5 mg intramuscularly every 6 months		
<input type="checkbox"/> Valstar® (valrubicin)	<input type="checkbox"/> 200 mg single-use vials	<input type="checkbox"/> Instill 800 mg intravesically every week for 6 weeks <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Xtandi® (enzalutamide)	<input type="checkbox"/> 40 mg tablets <input type="checkbox"/> 40 mg capsules <input type="checkbox"/> 80 mg tablets	<input type="checkbox"/> Take 160 mg orally once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Zoladex® (goserelin acetate implant)	<input type="checkbox"/> Implant 3.6 mg <input type="checkbox"/> Implant 10.8 mg	<input type="checkbox"/> Inject 3.6 mg subcutaneously every 28 days <input type="checkbox"/> Inject 10.8 mg subcutaneously every 3 months		
<input type="checkbox"/> Zytiga® (abiraterone acetate)	<input type="checkbox"/> 250 mg tablets <input type="checkbox"/> 500 mg tablets	<input type="checkbox"/> Take 1,000 mg orally once daily on an empty stomach <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Prednisone	<input type="checkbox"/> 5 mg tablets	<input type="checkbox"/> Take 5 mg orally once daily with food <input type="checkbox"/> Take 5 mg orally twice daily with food <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other				

DELIVERY INFORMATION

Need by: _____ Deliver to: Patient's home MD Office/ Clinic Other: _____

PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: _____ DAW Date: _____

*Signature on this form also provides consent to contact this patient's insurance provider for this prescription on the provider's behalf.

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IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.