Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe NPI # 1659380772 or NCPDP # 3306986

CareMed SPECIALTY PHARMACY

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
☐ **Abiraterone Acetate**	☐ 250 mg tablets	☐ Take 1,000 mg orally once daily on an empty stomach ☐ **Other:** _____		
☐ **with Prednisone**	☐ 5 mg tablets	☐ Take 5 mg orally once daily with food ☐ Take 5 mg orally twice daily with food ☐ **Other:** _____		
☐ **Bicalutamide**	☐ 50 mg tablets	☐ Take 150 mg orally once daily ☐ **Other:** _____		
☐ **Eligard®** (leuprolide acetate)	☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg	☐ Inject 7.5mg subcutaneously every month ☐ Inject 22.5mg subcutaneously every 3 months ☐ Inject 30mg subcutaneously every 4 months ☐ Inject 45mg subcutaneously every 6 months		
☐ **Erleada®** (apalutamide)	☐ 60 mg tablets ☐ 240 mg tablets	☐ Take 240 mg orally once daily ☐ **Other:** _____		
☐ **Firmagon®** (degarelix for injection)	☐ 120 mg/vial ☐ 80 mg/vial	☐ **Loading Dose:** Inject two 120 mg injections subcutaneously ☐ **Maintenance Dose:** Inject 80 mg injections subcutaneously every 28 days (initiate 28 days after loading dose) ☐ **Other:** _____		
☐ **Flutamide**	☐ 125 mg capsules	☐ Take 250 mg orally every 8 hours		
☐ **Lupron Depot®** (leuprolide acetate)	☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg	☐ Inject 7.5 mg intramuscularly every month ☐ Inject 22.5 mg intramuscularly every 3 months ☐ Inject 30 mg intramuscularly every 4 months ☐ Inject 45 mg intramuscularly every 6 months		
☐ **Nubeqa®** (darolutamide)	☐ 300 mg tablets	☐ Take 600 mg orally twice daily with food ☐ **Other:** _____		
☐ **Orgovyx®** (relugolix) (Cycle 1 only)	☐ 120 mg tablets	☐ Take 360 mg orally on the first day of treatment followed by 120 mg taken orally once daily at approximately the same time each day	30	0
☐ **Orgovyx®** (relugolix) (Maintenance Cycles) *Patient has completed the loading dose	☐ 120 mg tablets	☐ Take 120 mg orally once daily at approximately the same time each day		

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.

CM-805 4.23

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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:_____

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MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
☐ **Tice® BCG**		☐ Instill 50 mg intravesically weekly for 6 weeks ☐ Instill 50 mg intravesically every month		
☐ **Trelstar® (triptorelin)**	☐ 3.75 mg ☐ 11.25 mg ☐ 22.5 mg	☐ Inject 3.75 mg intramuscularly every month ☐ Inject 11.25 mg intramuscularly every 3 months ☐ Inject 22.5 mg intramuscularly every 6 months		
☐ **Valstar® (valrubicin)**	☐ 200 mg single-use vials	☐ Instill 800 mg intravesically every week for 6 weeks ☐ **Other:**_____		
☐ **Xtandi® (enzalutamide)**	☐ 40 mg tablets ☐ 40 mg capsules ☐ 80 mg tablets	☐ Take 160 mg orally once daily ☐ **Other:** _____		
☐ **Zoladex® (goserelin acetate implant)**	☐ Implant 3.6 mg ☐ mplant 10.8 mg	☐ Inject 3.6 mg subcutaneously every 28 days ☐ Inject 10.8 mg subcutaneously every 3 months		
☐ **Zytiga® (abiraterone acetate)**	☐ 250 mg tablets ☐ 500 mg tablets	☐ Take 1,000 mg orally once daily on an empty stomach ☐ **Other:** _____		
☐ **with Prednisone**	☐ 5 mg tablets	☐ Take 5 mg orally once daily with food ☐ Take 5 mg orally twice daily with food ☐ **Other:** _____		
☐ **Other**				

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