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

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 ☐ 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: ______		
☐ 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 6.24

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.

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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: ______________

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Comorbidities: ______________________ Known Allergies: ______________________

MEDICATIONS: You may tape Prescriptions here prior to faxing

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				

DELIVERY INFORMATION

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PRESCRIBER'S SIGNATURE REQUIRED

MD | NP | PA Signature: ______________________ ☐ **DAW** **Date:** ______________

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