



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	<input type="checkbox"/> Take 1,000 mg by mouth once daily on an empty stomach <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 sq QM <input type="checkbox"/> Inject sq Q4M <input type="checkbox"/> Inject sq Q3M <input type="checkbox"/> Inject sq Q6M		
<input type="checkbox"/> Firmagon® (degarelix)	<input type="checkbox"/> 120 mg/vial <input type="checkbox"/> 80 mg/vial	<input type="checkbox"/> Starting Dose: Inject two 120 mg injections sq <input type="checkbox"/> Maintenance Dose: Inject 80 mg injections sq Q28day <input type="checkbox"/> Other: _____		
<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 30 mg IM Q4M <input type="checkbox"/> Inject 22.5 mg IM Q3M <input type="checkbox"/> Inject 7.5 mg IM QM <input type="checkbox"/> Inject 45 mg IM Q6M		
<input type="checkbox"/> Tecentriq® (atezolizumab)	<input type="checkbox"/> 1200 mg/20 mL injection solution	<input type="checkbox"/> Infuse over 60 minutes Q3W		
<input type="checkbox"/> Tice® BCG		<input type="checkbox"/> Instill 50 mg intravesically QW X 6W <input type="checkbox"/> Instill 50 mg intravesically QM		
<input type="checkbox"/> Trellstar® (triptorelin pamoate)	Injectable Suspension	<input type="checkbox"/> Inject 3.75 mg IM QM <input type="checkbox"/> Inject 11.25 mg IM Q3M <input type="checkbox"/> Inject 22.5 mg IM Q6M		
<input type="checkbox"/> Valstar® (valrubicin)	<input type="checkbox"/> 200 mg single-use vials	<input type="checkbox"/> Instill 800 mg intravesically QW X 6W <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Vantas® (histreltin acetate)	<input type="checkbox"/> Subcutaneous implant 50 mg	<input type="checkbox"/> Insert 50mg implant surgically Q12M		
<input type="checkbox"/> Xtandi® (enzalutamide)	<input type="checkbox"/> 40 mg	<input type="checkbox"/> Take 160 mg by mouth once daily <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Zoladex® (goserelin acetate)	<input type="checkbox"/> Implant 3.6 mg <input type="checkbox"/> Implant 10.8 mg	<input type="checkbox"/> Inject 3.6 mg sq Q28day <input type="checkbox"/> Inject 10.8 mg sq Q3M		
<input type="checkbox"/> Zometa® (zoledronic acid)	<input type="checkbox"/> 4 mg per 100 mL single-use ready-to-use bottle <input type="checkbox"/> 4 mg per 5 mL single-use vial of concentrate	<input type="checkbox"/> Infuse 4 mg/5 ml Q3M		
<input type="checkbox"/> Zytiga® (abiraterone acetate)	<input type="checkbox"/> 250 mg	<input type="checkbox"/> Take 1,000 mg by mouth once daily on an empty stomach <input type="checkbox"/> Other: _____		
<input type="checkbox"/> with Predisone	<input type="checkbox"/> 5 mg	<input type="checkbox"/> Take 5 mg by mouth once daily with food <input type="checkbox"/> Take 5 mg by mouth twice daily with food		
<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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