Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe ID # 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	☐ 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 50 mg orally once daily ☐ 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	☐ 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: ______		
☐ 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

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 11.21

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.