Ph: 877.227.3405 • Fax: 877.542.2731 • E-Prescribe ID # 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	☐ Take 1,000 mg by mouth once daily on an empty stomach ☐ Other: _____		
☐ **Eligard®** (leuprolide acetate)	☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg	☐ Inject sq QM ☐ Inject sq Q4M ☐ Inject sq Q3M ☐ Inject sq Q6M		
☐ **Firmagon®** (degarelix)	☐ 120 mg/vial ☐ 80 mg/vial	☐ **Starting Dose**: Inject two 120 mg injections sq ☐ **Maintenance Dose**: Inject 80 mg injections sq Q28day ☐ Other: _____		
☐ **Lupron Depot®** (leuprolide acetate)	☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg	☐ Inject 30 mg IM Q4M ☐ Inject 22.5 mg IM Q3M ☐ Inject 7.5 mg IM QM ☐ Inject 45 mg IM Q6M		
☐ **Tecentriq®** (atezolizumab)	☐ 1200 mg/20 mL injection solution	☐ Infuse over 60 minutes Q3W		
☐ **Tice® BCG**		☐ Instill 50 mg intravesically QW X 6W ☐ Instill 50 mg intravesically QM		
☐ **Trelstar®** (triptorelin pamoate)	Injectable Suspension	☐ Inject 3.75 mg IM QM ☐ Inject 11.25 mg IM Q3M ☐ Inject 22.5 mg IM Q6M		
☐ **Valstar®** (valrubicin)	☐ 200 mg single-use vials	☐ Instill 800 mg intravesically QW X 6W ☐ **Other:**_____		
☐ **Vantas®** (histrelin acetate)	☐ Subcutaneous implant 50 mg	☐ Insert 50mg implant surgically Q12M		
☐ **Zoladex®** (goserelin acetate)	☐ Implant 3.6 mg ☐ Implant 10.8 mg	☐ Inject 3.6 mg sq Q28day ☐ Inject 10.8 mg sq Q3M		
☐ **Zometa®** (zolcdronic acid)	☐ 4 mg per 100 mL single-use ready-to-use bottle ☐ 4 mg per 5 mL single-use vial of concentrate	☐ Infuse 4 mg/5 ml Q3M		
☐ **Zytiga®** (abiraterone acetate)	☐ 250 mg	☐ Take 1,000 mg by mouth once daily on an empty stomach ☐ Other: _____		
☐**with Predisone**	☐ 5 mg	☐ Take 5 mg by mouth once daily with food ☐ Take 5 mg by mouth twice daily with food		
☐**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 12.18