For assistance, contact your pharmacy representative: _____ Phone: _____ **(For providers only)**

Note: This form is intended for prescriber use only. If faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

Urology

Prescription/Pharmacy intake form

Pharmacy: _____

Pharmacy fax: _____ Pharmacy phone: _____

Date needed: _____ **Ship to:** ☐Prescriber's office ☐Patient's home ☐Other: _____

Patient information

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ ZIP code: _____

Phone (daytime): _____ Phone (evening): _____

Email address: _____ Case manager: _____

Primary insurance: _____

Patient's ID #: _____

Cardholder's name (if not patient): _____

Cardholder's DOB (if not patient): _____

Phone w/area code: _____

Group #: _____

Secondary insurance: _____

Patient's ID #: _____

Cardholder's name (if not patient): _____

Cardholder's DOB (if not patient): _____

Phone w/area code: _____

Group #: _____

Clinical assessment – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: _____

Primary diagnosis code and condition (ICD-10): _____ Date of diagnosis: _____

Medical history: _____

Allergies: _____

Prescription information

Medication	Form	Strength	Quantity	Directions/Frequency	Dose	Refills
Eligard		☐7.5 mg		Sub-Q every month		
		☐22.5 mg		Sub-Q every 3 months		
		☐30 mg		Sub-Q every 4 months		
		☐45 mg		Sub-Q every 6 months		
Firmagon	Kit (2 = 1 kit)	☐120 mg (240 mg)				
	SDV	☐80 mg				
Lupron Depot		☐7.5 mg		IM every month		
		☐22.5 mg		IM every 3 months		
		☐30 mg		IM every 4 months		
		☐45 mg		IM every 6 months		
☐Sodium chloride sterile preservative-free vial						
TICE BCG		☐50 mg				
☐Sodium chloride sterile preservative-free vial						
Trelstar		☐3.75 mg		IM every 4 weeks		
		☐11.25 mg		IM every 12 weeks		
		☐22.5 mg		IM every 24 weeks		
Vantas	Implant	☐50 mg				
Zoladex	Implant kit	☐3.6 mg		Sub-Q every 28 days		
		☐10.8 mg		Sub-Q every 12 weeks		

I authorize, by my signature below, the dispensing of appropriate needles and syringes in a sufficient quantity required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

Prescriber information

Prescriber's name: _____ Practice/Facility: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Office contact: _____ Phone: _____ Fax: _____

Email: _____ Best time to call: _____ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand necessary"** or **"Brand medically necessary,"** or your state-specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature required on one of the lines below.

_____ Dispense as written

_____ Substitution permitted

_____ Date

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements could result in outreach to the prescriber.