Urologic Oncology Rx Referral Form

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E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: __________ Ship To: ☐ Patient's Home ☐ Prescriber's Office ☐ Or Pick-up from Pharmacy

Injection needed by pharmacy? ☐ Yes ☐ No

1: Patient Information

Patient Name: __________ Birthdate: __________ Sex: Male Female Height: ______ Weight: ______ lbs. kg.

Soc. Sec. #: __________ Preferred Phone: __________ Known Allergies: __________

Address: __________ City: __________ State: ______ Zip: ______

Alternate Caregiver Name: __________ Preferred Phone: __________

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Complete this section ONLY if you would like Park Avenue Pharmacy to initiate a Prior Authorization of Appeal on your behalf:

Prior therapy	Reason for discontinuation of therapy	Year of discontinuation
	O Disease Progression O Finished Therapy O Toxicity (please specify) __________	

3: Prescriber Information

Prescriber Name: __________ DEA#: ______ NPI#: ______ Tax ID#: ______

Address: __________ Phone: (____) ______ - ______ Fax: (____) ______ - ______

City: __________ State: ______ Zip: ______ Key Contact: __________ Phone: (____) ______ - ______

4: Prescription Information

Medication	Dose/Strength	Directions	Qty.	Refills
☐ **Lupron Depot**	☐ 7.5 mg kit (1 month) ☐ 22.5 mg kit (3 months) ☐ 30 mg kit (4 months) ☐ 45 mg kit (6 months)	☐ Inject 7.5 mg IM once every month ☐ Inject 22.5 mg IM once every 3 months ☐ Inject 30 mg IM once every 4 months ☐ Inject 45 mg IM once every 6 months	1	
☐ **Zytiga**	☐ 250 mg tablet	☐ Take 4 tablets (1000 mg by mouth once daily on an empty stomach, 1 hour before or 2 hour after eating)	120	
☐ **Casodex**	☐ 50 mg tablet	☐ Take 1 tablet by mouth once daily	30	
☐ **Xtandi**	☐ 40 mg tablet	☐ Take 4 capsules (160 mg) by mouth once daily	120	
☐ **Prednisone**	☐ 5 mg tablet	☐ Take 1 tablet by mouth twice daily with food Other: __________	☐ 60 ☐ ___	
☐ **Firmagon** (Degarelix for injection)	☐ 120 mg vial ☐ 80 mg vial	☐ Starter Dose: 240 mg is given as two injections of 120 mg each subcutaneously ☐ Maintenance Dose: Inject 80 mg subcutaneously as a single injection every 28 days		

O **Aranesp** O **Emend** O **Naulasta** O **Neupogen**
O **Sancuso** O **Zofran** O **Relistor** O **Procrit**

DOSING & SIG:

QTY: __________ Refill: __________

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: __________ Date: __________

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable __________ Date __________ Dispense as written __________ Date __________

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.