



Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

Deliver Here

Patient Name: _____

Address: _____

City, State, Zip: _____

Primary Phone: _____ DOB: _____

Alternate Phone: _____ Gender: Male Female

Email: _____

Last 4# of SS: _____

PRESCRIBER INFORMATION

Deliver Here

Name: _____

State License #: _____ NPI: _____

DEA #: _____ Tax ID _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

DIAGNOSIS AND CLINICAL INFORMATION

Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization Medication

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____

Renal Dysfunction: Yes No Liver Dysfunction: Yes No H/H (Hemoglobin/Hematocrit): _____

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

Date and value of last HbA1c _____ Date and value of last Serum PSA _____

Date and value of last Serum Testosterone _____ Date of Orchiectomy _____ / _____ / _____

Medication	Dose/Strength	Directions	Qty.	Refills
Lupron Depot®				
Trelstar®				
Eligard®				
Firmagon®				
Casodex®				
Nilandron®				
Zoladex®				
Eulexin®				
Valstar®				
Mitomycin				
Xgeva®	120-mg dose (1.7-mL injection)	Administer once every 4 weeks		
Zytiga®	250 mg	Take 4 tablets daily without food		
With Prednisone	5mg	<input type="checkbox"/> 5mg BID with food Other:		

Shipped to: HOME OFFICE

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: _____

Date: _____

Dispense as written

Date

Substitution Permissible

Date

I authorize Medical Center Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. 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. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289

3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102

