UROLOGY ENROLLMENT FORM

Phone: (813) 871-5161 ext. 34993
Fax: (813) 877-2479

PATIENT INFORMATION (OR ATTACH PATIENT DEMOGRAPHIC SHEET)			
Patient Name:	☐Male ☐Female	Allergies: ☐NKDA	
Date of Birth:	SSN:	Weight: ☐kg ☐lb	Date:
Address:	City:	State:	Zip:
Phone # (Home):	Work #:	Email (Optional):	
INSURANCE INFORMATION (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS, IF AVAILABLE)			
Primary Insurance:	RX Bin:	RX PCN:	
RX Group:	RX ID:	RX Phone:	
Policy Holder's Name:	Policy Holder's DOB:	Policy Holder's SSN:	
DIAGNOSIS/MEDICAL INFORMATION (COMPLETE CLINICAL INFO BELOW OR ATTACH PATIENTS LABS)			
☐ C61 Malignant Neoplasm of Prostate	☐ Other ICD-10:	Date of Last Labs: / /	
Previous Treatment:			

PRESCRIPTION INFORMATION				
MEDICATION	**STRENGTH/DOSE**	**DIRECTIONS**	**QTY**	**REFILLS**
Oncology - Oral				
☐ Nilandron®	☐ 150 mg	☐ Initial Dose: Take two tablets (300 mg) by mouth once a day for one month. ☐ Maintenance Dose: Take one table (150 mg) by mouth once daily.		
☐ Zytiga® ***MUST BE DISPENSED WITH PREDNISONE** ☐ Prednisone	☐ 250 mg ☐ 500 mg ***MUST BE DISPENSED WITH PREDNISONE** ☐ 5 mg	☐ Take 1,000 mg by mouth daily ***MUST BE DISPENSED WITH PREDNISONE** ☐ Take one tablet by mouth twice a day ☐ Take one tablet by mouth once day		
Oncology – Inj. / IV				
☐ Eligard®		SIG:		
☐ Firmagon® ***MUST ALWAYS SEND TO MDO**	☐ 120 mg ☐ 80mg	**Starting Dose:** ☐ 240 mg subcutaneously given as two injections of 120 mg each. **Maintenance Dose:** ☐ 80 mg subcutaneously every 28 days. Must be reconstituted before use.		
☐ Lupron®		SIG:		
☐ Trelstar®		SIG:		

DELIVERY INSTRUCTIONS		
☐ Physician's Office	☐ Patient's Home	☐ 1st dose MD office, Refills to patient's home
PHYSICIANS CONTACT INFORMATION & AUTHORIZATION		
Physician's Name:	Office Contact:	Institution:
Phone #:	Fax #:	Specialty:
Address:	City/State/Zip:	
Tax ID:	DEA #:	NPI #:
Physician's Signature:		Date:

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender and destroy all copies of the original document. Created:08/28/18 Revised: 05/01/19, 08/22/19, 02/24/20