



UROLOGY REFERRAL FORM

Single Point of Contact: 724-515-7053 Pharmacy 866-213-9821

FAX: 877-526-8823

Start Date: _____

Ship To: Patient Office Other

1. Patient Information:

Please fax front and back copy of the insurance card

Patient: _____ Male / Female DOB: _____ Soc. Sec. # _____
First Name Last Name

Address: _____
Street City State Zip

Primary phone number: _____ Alternate phone number: _____

Caregiver: _____ Allergies: _____

Comorbidities: _____ Height: _____ Weight: _____

2. Clinical information:

Please FAX recent clinical notes, Labs, Tests, with prescription to expedite the prior authorization

Diagnosis/ ICD-10: _____ Serum Creatinine: _____ Any prior treatment: (YES / NO) (provide information below)

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 _____ / _____ / _____

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

3. Prescription Information:

If you need a medication not listed please contact us

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Casodex®	<input type="checkbox"/> 50mg tablets	<input type="checkbox"/> Take one tablet PO once daily <input type="checkbox"/> Other _____	<input type="checkbox"/> 30 Tablets <input type="checkbox"/> Other _____	
<input type="checkbox"/> Eligard®	<input type="checkbox"/> 7.5mg once every month <input type="checkbox"/> 22.5mg once every 3 months <input type="checkbox"/> 30mg once every 4 months <input type="checkbox"/> 45mg once every 6 months	<input type="checkbox"/> Inject 1 PFS Sub-Q	<input type="checkbox"/> 1 Kit	
<input type="checkbox"/> Lupron®	<input type="checkbox"/> 7.5mg once every month <input type="checkbox"/> 22.5mg once every 3 months <input type="checkbox"/> 30mg once every 4 months <input type="checkbox"/> 45mg once every 6 months	<input type="checkbox"/> Inject 1 PFS intramuscularly	<input type="checkbox"/> 1 Kit	
<input type="checkbox"/> Nilandron®	<input type="checkbox"/> 150mg	<input type="checkbox"/> Take 2 tablets daily for 30 days <input type="checkbox"/> Take 1 tablet daily		
<input type="checkbox"/> Xgeva®	<input type="checkbox"/> 120mg Vial	<input type="checkbox"/> Administer Sub-Q every 4 weeks <input type="checkbox"/> Other _____		
<input type="checkbox"/> Zoladex®	<input type="checkbox"/> 10.8mg PFS <input type="checkbox"/> 3.6 mg PFS	<input type="checkbox"/> Inject Sub-Q every 12 weeks into anterior abdominal wall below the navel line. <input type="checkbox"/> Other _____		
<input type="checkbox"/>				

Supportive Medications:

Authorization # :

Aranesp® Neupogen®
 Arixtra® Nplate®*
 Caphosol® Procrit®
 Emend® Promacta®
 Lovenox® Sancuso®
 Neulasta® Zarxio®

Zofran®
 Other _____

Strength/Directions (SIG):

Strength/Directions (SIG):

Refill #: QTY:

Refill #: QTY:

Strength(s): _____ Directions: _____

Quantity: _____ Refills: _____ **Authorization: _____

Packaging: Bottles AccuPac™

4. Prescriber and Shipping Information

Prescriber (print) _____ Office Contact: _____

Preferred method of contact: phone fax email preferred contact persons email: _____

Office Address: _____

Phone: _____ fax: _____ NPI: _____ DEA: _____

Prescriber's Signature: _____ Date: _____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process (NO STAMPS)

5. Patient Support Programs:

Please sign below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: _____ Date: _____

6. Insurance Information:

Please fax a copy of the insurance card (front & back)

*IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee it contains materials that are confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named address you should not disseminate distribute or copy this fax. Please notify the sender immediately if you received this document in error and destroy this document immediately. Please fax completed form to AccuServ Pharmacy at 877-526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.