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 **(Prescription and Medical)**

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 ÁÕÔÈÌÒÉÚÁÔÉÏ Î

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
☐ Casodex®	☐ 50mg tablets	☐ Take one tablet PO once daily ☐ Other_____	☐ 30 Tablets ☐ Other_____	
☐ Eligard®	☐ 7.5mg once every month ☐ 22.5mg once every 3 months ☐ 30mg once every 4 months ☐ 45mg once every 6 months	☐ Inject 1 PFS Sub-Q	☐ 1 Kit	
☐ Lupron®	☐ 7.5mg once every month ☐ 22.5mg once every 3 months ☐ 30mg once every 4 months ☐ 45mg once every 6 months	☐ Inject 1 PFS intramuscularly	☐ 1 Kit	
☐ Nilandron®	☐ 150mg	☐ Take 2 tablets daily for 30 days ☐ Take 1 tablet daily		
☐ Xgeva®	☐ 120mg Vial	☐ Administer Sub-Q every 4 weeks ☐ Other_____		
☐ Zoladex®	☐ 10.8mg PFS ☐ 3.6 mg PFS	☐ Inject Sub-Q every 12 weeks into anterior abdominal wall below the navel line. ☐ Other_____		
☐				

Supportive Medications:

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

Authorization # :

Strength/Directions (SIG):

Refill #: **QTY:**

Strength/Directions (SIG):

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 (optional):

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)