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

Urology Enrollment Form

Fax: (877) 526-8823

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

Start Date:___________ **Ship to:** ___ Patient ___ Office ____________Other

1. Patient Information

Patient Name: ____ M / F DOB:______________SSN:_______________
Address: ____Phone #: _____________
Comorbidities:____________________________ Allergies: ________________________________ Weight: ___________

2. Clinical Information *please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:_______________________ Serum Creatinine: ____________ Serum PSA: ___________
Prior Treatments:________________________________Serum Testosterone: ___________ HbA1c: ______________
Renal Dysfunction: Y / N Liver Dysfunction: Y / N Date of Orchiectomy: ____________ H/H : ______________

3. Prescription Information *if your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions (be specific)	Quantity	Refills
	Casodex®	__ 50 mg	__ Take _______ mg by mouth _____ times per day	_______ tabs	
	Eligard®	__ 7.5 mg 1x every month __ 22.5 mg 1x every 3 months __ 30 mg 1x every 4 months __ 45 mg 1x every 6 months	__ Inject 1 PFS Sub-Q	__ 1 kit	
	Lupron®	__ 7.5 mg 1x every month __ 22.5 mg 1x every 3 months __ 30 mg 1x every 4 months __ 45 mg 1x every 6 months	__ Inject 1 PFS IM	__ 1 kit	
	Nilandron®	__ 150 mg	__ Take _________ tablets daily	_______ tabs	
	Xgeva®	__ 120 mg	__ Inject __________mg Sub-Q every _____weeks	_______ vials	
	Zoladex®	__ 3.6 mg __ 10.8 mg	__ Inject _______ mg Sub-Q every ______weeks into anterior abdominal wall, below the navel	_______PFS	

Authorization #: ____

Supportive Medications		Choice 1:	Choice 2:
❑ **Aranesp®** ❑ **Arixtra®** ❑ **Caphosol®** ❑ **Emend®** ❑ **Lovenox®** ❑ **Neulasta®** ❑ **Neupogen®**	❑ **Nplate®** ❑ **Procrit®** ❑ **Promacta®** ❑ **Sancuso®** ❑ **Zarxio®** ❑ **Zofran®** ❑ ________________	**Strength:** **Sig:** **Qty:** **Refills:**	**Strength:** **Sig:** **Qty:** **Refills:**

Please fax a list of patient's other medications & choose packaging: ______ AccuPAC® ______ Bottles
❑ **Check Here** to receive more information about our custom compliance packaging *AccuPAC®*

4. Prescriber and Shipping Information

Prescriber (print) : ____ Office Contact: _________________________
Pref. Method of Contact: __ phone __ fax __ email Contact email: ____________________________________
Office Address: ____
Phone: ___________________________ Fax: _________________________ NPI: _________________________

Prescriber's Signature:____ Date: _________DEA:_____________
I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

IMPORTANT NOTICE:this fax is intended to be delivered only to the named address. 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.
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