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

AccuSERV® PHARMACY

Urology Enrollment Form

Clear 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	
☐	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.

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.