ePrescribe to our Pharmacy " Quality RX **" located in "** 10453 **"**

Urology Referral Form **PHARMACY PHONE: 800-490-1755 FAX 877-678-8786**

QUALITY SPECIALTY PHARMACY

Prescriber's Name: _____

DEA #: _____ NPI: _____

Address: _____

Date: _____ Needs by Date: _____

City, State, Zip: _____

Language: _____ ☐ Nursing Instruction Required

Phone: _____ Fax: _____

Ship to: ☐ Patient ☐ MD Office ☐ Other: _____

Office Contact: _____

PATIENT INFORMATION: Please complete the following or send patient demographic sheet

Patient Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Height: _____ Weight: _____ lbs Allergies: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Alternate: _____ Email: _____

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFORMATION

CLINICAL INFORMATION: Please send recent clinical notes, current medications, labs, and tests to expedite the **Prior Authorization**.

Diagnosis: _____ ICD-10: _____ Prior Failed Meds: _____ Duration: _____

Renal Dysfunction: ☐ Yes ☐ No Liver Dysfunction: ☐ Yes ☐ No Metastatic: ☐ Yes ☐ No Castration Resistant: ☐ Yes ☐ No

HbA1c _____ Date: _____ ☐ Bilateral Orchiectomy Date: _____ Hemoglobin/Hematocrit: _____

Serum Testosterone _____ Date: _____ Serum PSA _____ Date: _____ Serum Creatinine: _____

PRESCRIPTION INFORMATION

Medication	Strength	Directions	Quantity	Refill
☐ Mitomycin®	☐ 40 mg IV			
☐ Zytiga®	☐ 250 mg tablet	Take 4 Tablets (1000mg) once daily by mouth on an empty stomach	120	
	☐ 500 mg tablet	Take 2 Tablets (1000mg) once daily by mouth on an empty stomach	60	
☐ Prednisone	☐ 5 mg tablet	☐ Take 1 Tablet by mouth twice daily with food	60	
		☐ Other:		
☐ Xgeva®	☐ 120 mg vial			
☐ Eligard®	☐ 7.5 mg Syringe Kit	Administer subcutaneously once a month	1	
	☐ 22.5 mg Syringe Kit	Administer subcutaneously every 3 months	1	
	☐ 30 mg Syringe Kit	Administer subcutaneously every 4 months	1	
	☐ 45 mg Syringe Kit	Administer subcutaneously every 6 months	1	
☐ Lupron Depot®	☐ 7.5 mg Syringe Kit	Administer intramuscularly once a month	1	
	☐ 22.5 mg Syringe Kit	Administer intramuscularly every 3 months	1	
	☐ 30 mg Syringe Kit	Administer intramuscularly every 4 months	1	
	☐ 45 mg Syringe Kit	Administer intramuscularly every 6 months	1	
☐ Trelstar®	☐ 3.75 mg Syr ☐ 11.25 mg Syr ☐ 22.5 mg Syr			
☐ Firmagon®	☐ 120 mg vial	**Initial Dose**: Administer subcutaneously two 120-mg (240mg) doses		
	☐ 80 mg vial	**Maintenance Dose:** Administer subcutaneously 80 mg every 28 days		
☐ Viagra (Sildenafil)	☐ 20 mg tablet ☐ 100 mg tablet ☐ 50 mg tablet			
☐ Cialis (Tadalafil)	☐ 5 mg tablet ☐ 20 mg tablet ☐ 10 mg tablet			
Other:				

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Physician Signature: _____ Date_____ ☐ Do Not Substitute Intial _____