MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

UROLOGY

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:			Secondary Insurance:	
ID#:	RxBin:		ID#:	RxBin:
RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ DOCETAXEL	☐ _____MG/_____ML VIAL		_____VIAL(S)	
☐ ELIGARD	☐ 7.5MG KIT ☐ 22.5MG KIT ☐ 30MG KIT ☐ 45MG KIT	☐ Inject_____mg SQ every_____month(s) in healthcare setting	1 KIT	
☐ ERLEADA	☐ 60MG TABLET ☐ 120MG TABLET	☐ Take 4 tablets by mouth every day ☐ Take 1 tablet by mouth every day	[30] or [120]	
☐ GEMCITABINE	☐ 1G/26.3ML VIAL ☐ 25/52.6ML VIAL		_____VIAL(S)	
☐ GEMTESA	☐ 75MG TABLET	☐ Take 1 tablet by mouth every day	[30] or [90]	
☐ LUPRON	☐ 7.5MG KIT ☐ 22.5MG KIT ☐ 30MG KIT ☐ 45MG KIT	☐ Inject_____mg IM every_____month(s) in healthcare setting	1 KIT	
☐ MYRBETRIQ	☐ 25MG TABLET ☐ 50MG TABLET	☐ Take 1 tablet by mouth every day	[30] or [90]	
☐ NUBEQA	☐ 300MG TABLET	☐ Take 2 tablets by mouth twice a day with food	[120]	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (855) 595-2955

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RxGroup:	Pcn:		RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ ORGOVYX	☐ 120MG TABLET	☐ Take 1 tablet by mouth every day	[30]	
☐ PADCEV	☐ 20MG VIAL ☐ 30MG VIAL			
☐ TRELSTAR	☐ 3.75MG KIT ☐ 11.25MG KIT ☐ 22.5MG KIT	☐ Inject_____mg IM every_____month(s) in healthcare setting	1 KIT	
☐ XIAFLEX	☐ 0.9MG VIAL	☐ Administer as directed in healthcare setting	_____VIAL(S)	
☐ XTANDI	☐ 40MG TABLET ☐ 80MG TABLET ☐ 40MG CAPSULE	☐ Take 160mg by mouth every day	[60] or [120]	
☐ ZYTIGA	☐ 250MG TABLET ☐ 500MG TABLET	☐ Take_____mg by mouth daily		

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Phone: Fax:

***Prescriber Signature:** **Date:**

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