LIFECARE PHARMACY

www.lifecarepharmacy.com

Urology Referral Form

Surescripts ID #:

Office #: 1-210-881-0890
Fax #: 1-210-569-6464

Referral Info

PATIENT INFORMATION

PATIENT NAME		**SSN #:**		**DOB:**	
ADDRESS:		**CITY:**	**STATE:**	**ZIP:**	
HOME PHONE:	**CELL PHONE:**	**HEIGHT:**	**WEIGHT:**	**GENDER:**	**MALE FEMALE**
Email ADDRESS:		**DIAGNOSIS CODE:**			

INSURANCE INFORMATION (or attach copy of your cards)

Primary Insurance Co:	Phone:	Policy#:	Group#:
Secondary Insurance Co:	Phone:	Policy#:	Group#:

DIAGNOSIS/CLINICAL INFORMATION

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____

Renal Dysfunction: O Yes O No Liver Dysfunction: O Yes O No H/H (Hemoglobin/Hematocrit):_____

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans

O Labs/scans faxed O Chemo orders faxed O Labs/scans attached O Chemo orders attached

Date and value of last HbA1c _____ Date and value of last Serum PSA _____

Date and value of last Serum Testosterone _____ Date of Orchiectomy_____ / _____ / _____

Current GnRH antagonist therapy: O Lupron O Zoladex O Firmagon OR O bilateral orchiectomy

Prescription INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY	REFILLS
o Erleada™	60 MG	Take 4 (60mg) tablets by mouth dailyGive with a gonadotropin-releasing hormone (GnRH) analog if the patient has not had a bilateral orchiectomy		
o Zytiga®	250 MG	Take 4 tablets daily without foo		
o With Prednisone	5 MG	o 5mg BID with food o Other:		
o Xgeva®				
o Xtandi®				
o Casodex®				
o Eligard®				
o Lupron®				
o Nilandron®				
o Zoladex®				

PHYSICIAN INFORMATION

Prescriber Name:	**Phone:**	**Fax:**
Office Contact/Faxed by:	**Email:**	
NPI#:	**TAXID#:**	**Ship To: O Patient O MD 1ST Fill Only O MD All Orders**
Prescriber Signature:		
○ **Dispense as written**	**Date**	

Your signature authorizes the pharmacy to act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

* We will let you know within 2 hours if your patient can be admitted pending insurance Qualification or non-admitted and triaged to another pharmacy

This prescription is valid only if transmitted by Facsimile machine by a licensed prescriber

LIFECARE PHARMACY