MAIN POINT OF CONTACT

Name:_____

Phone:_____

ASP CARES

Urology Oral Medications

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

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/Strength	Directions	Qty	Refills
☐ Xtandi	40mg	☐ 4 capsules po once daily #120 ☐ Other:_____		
☐ Zytiga	250mg	☐ 4 tablets po once daily #120 ☐ Other:_____		
☐ Prednisone	5mg	☐ 1 tablet po twice daily #60 ☐ Other:_____		

℞

Allergies:

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:_____**

Please fax completed form to 1 (888) 294-9434