



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

MAIN POINT OF CONTACT

Name: _____

Phone: _____

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
<input type="checkbox"/> Xtandi	40mg	<input type="checkbox"/> 4 capsules po once daily #120 <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Zytiga	250mg	<input type="checkbox"/> 4 tablets po once daily #120 <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Prednisone	5mg	<input type="checkbox"/> 1 tablet po twice daily #60 <input type="checkbox"/> 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: _____**

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