Urology Prescription Referral Form

Carepoint Pharmacy
Phone: 732-885-1000 **Fax: 732-980-0357**
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Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name :	*Middle Initial :*	*Last Name :*	
Date of Birth :	*Gender:* ◯ M ◯ F	*SSN :*	
Street Address :	*City :*	*State :*	*Zip Code :*
Home Phone :	*Work Phone :*	*Cell Phone :*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name - Primary :	*Name of Insured :*		*Relationship :*
ID# :	*Group # :*		*Insurance Phone :*
Rx Carrier Name - Secondary :	*Rx ID# :*	*Rx Group #:*	*Rx Phone # :*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription			
Drug Name	**Form/Strength/Directions for Use**	**Qty**	**Refills**
Xtandi (40mg tabs only)	☐ 160mg PO daily ☐ Other _____		
Eligard	☐ 7.5mg SC every 4 weeks **Delivery to :** ☐ MD ☐ Patient ☐ 22.5mg SC every 12 weeks ☐ 30mg SC every 16 weeks ☐ 45mg SC every 24 weeks		
Lupron - Depot	☐ 7.5mg IM every 4 weeks **Delivery to :** ☐ MD ☐ Patient ☐ 22.5mg IM every 12 weeks ☐ 30mg IM every 16 weeks		
Prednisone	☐ _____ mg PO daily ☐ Other _____		
Trelstar	☐ 3.75 mg IM every 4 weeks **Delivery to :** ☐ MD ☐ Patient ☐ 11.25mg IM every 12 weeks ☐ 22.5mg IM every 24 weeks		
Zytiga (250mg tabs only)	☐ _____ mg PO daily		
Zoladex	☐ 3.6 mg SC every 4 weeks **Delivery to :** ☐ MD ☐ Patient ☐ 10.8 mg SC every 12 weeks		
Casodex	☐ 50 mg PO daily		
Other Medications	_____ Medication _____ Direction		

Clinical Data			
Primary Diagnosis:	*ICD - 9 :*	*Weight :*	*Height :*
Allergies :			
Failed Therapies :			
Current Therapies/Medications:			

Complete Prescriber Information in Section Below NOT Included on Attached Prescription				
MD First Name :	*MD Last Name :*	*DEA # :*		
UPIN :	*State License # :*	*NPI :*		
Office Address :		*City :*	*State :*	*Zip Code :*
Office Phone:		*Office Fax :*		*Office Contact Name :*
Office Contact Name:		*Office Email:*		

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS	
☐ *I authorize Carepoint Pharmacy to initiate a Prior Authorization on my behalf.*	**Date :** _____
Dr : Substitution Permitted	**Dr :** No Substitution Permitted