

Urology Referral Form

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 cards)

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

PRESCRIPTION INFORMATION (for IV medication attach a copy of prescription)

Abiraterone (*generic for Zytiga*)

250 mg tablet 500 mg tablet

Directions:

Take 1000 mg once daily by mouth on an empty stomach
 Other: _____

Qty: Refills:

PREDNISONE

CRPC: Take 5 mg by mouth twice daily with food
 CSPC: Take 5 mg by mouth once daily with food

Qty: Refills:

XTANDI® (*enzalutamide*)

40 mg tablets 40 mg capsule 80 mg tablet

Directions:

160 mg (FOUR 40 mg capsules or TWO 80 mg tablets) administered orally once daily.

Qty: Refills:

ERLEADA™ (*apalutamide*) 60 mg tablet

Directions:

Take 240 mg (FOUR 60 mg tablets) once daily

Qty: Refills:

YONSA® (*abiraterone*) 125 mg tablet

Directions:

Take 500 mg (FOUR 125 mg tablets) by mouth once daily

Qty: Refills:

METHYLPREDNISOLONE

Take 4 mg by mouth twice daily with food

Qty: Refills:

Start of Therapy Date:

***If patient has not had a bilateral orchiectomy or currently on gonadotropin-releasing hormone (GnRH) analog therapy, prescribe below in "Other." ***

LHR Agonist

- TRELSTAR® (*triptorelin*)
- ZOLADEX® (*goserelin*)
- VANTAS® (*histrelin*)
- ELIGARD® (*leuprolide*)
- LUPRON DEPOT® (*leuprolide*)

1st Generation Antiandrogens:

- NILANDRON® (*nilutamide*)
- EULEXIN® (*flutamide*)
- CASODEX® (*bicalutamide*)

Please use this section for additional directions or other medications not listed.

OTHER

STRENGTH:

SIG/DIRECTIONS:

QUANTITY:

REFILLS:

Start of Therapy Date:

Special Delivery Instructions:

Ship To:

Patient MD Office 1st Order Only MD Office All Orders

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.

Dispense as written

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:		Email:			
Address:					
NPI #:			Tax ID #		
Prescriber Signature:			Date:		