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UROLOGY

DATE NEEDED BY ..... SHIP to ☐ PATIENT ☐ OFFICE ☐ OTHER .....

PATIENT INFORMATION

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAIN PHONE _____ ALTERNATE PHONE _____

SS# _____ DOB _____

☐ MALE ☐ FEMALE HEIGHT _____ WEIGHT _____ AGE _____

PRESCRIBER INFORMATION

PRESCRIBER NAME _____

DEA # _____ NPI _____ STATE LICENSE# _____

GROUP|HOSPITAL _____

ADDRESS _____

CITY, STATE, ZIP _____

MAIN PHONE _____ FAX _____

CONTACT PERSON _____ PHONE _____

PLEASE FAX COPY OF ☐ PRESCRIPTION CARD FRONT AND BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT AND BACK

CLINICAL AVALUATION

DIAGNOSIS _____ ICD - 10 _____

SERUM PSA LEVEL _____ DATE OBTAINED _____ HEIGHT _____ WEIGHT _____

DRUG ALLERGIES _____

PRIOR FAILED MEDS _____ LENGTH OF TREATMENT _____ REASON FOR DISCONTINUING _____

_____ LENGTH OF TREATMENT _____ REASON FOR DISCONTINUING _____

_____ LENGTH OF TREATMENT _____ REASON FOR DISCONTINUING _____

IS THE PROSTATE CANCER METASTATIC? ☐ YES ☐ NO IS THE PROSTATE CANCER CASTRATION RESISTANT? ☐ YES ☐ NO

PRESCRIPTION INFORMATION

			QUANTITY	REFILLS
☐ CASODEX	50mg TABLETS	TAKE 1 TABLET BY MOUTH ONCE DAILY	30	_____
☐ ELIGARD	☐ 7.5mg SYRINGE (1 MONTH SUPPLY)	ADMINISTER SUBCUTANEOUSLY ONCE A MONTHS	1	_____
	☐ 22.5mg SYRINGE (3 MONTH SUPPLY)	ADMINISTER SUBCUTANEOUSLY EVERY 3 MONTHS	1	_____
	☐ 30mg SYRINGE (4 MONTH SUPPLY)	ADMINISTER SUBCUTANEOUSLY EVERY 4 MONTHS	1	_____
	☐ 45mg SYRINGE (6 MONTH SUPPLY)	ADMINISTER SUBCUTANEOUSLY EVERY 6 MONTHS	1	_____
☐ FIRMAGON	☐ 120mg VIAL	LOADING DOSE: ADMINISTER SUBCUTANEOUSLY TWO - 120mg (240mg) DOSES	2	
	☐ 80mg VIAL	MAINTENANCE DOSE: ADMINISTER SUBCUTANEOUSLY 80mg EVERY 28 DAYS	1	_____
☐ LUPRON DEPOT	☐ 7.5mg KIT (1 MONTH SUPPLY)	ADMINISTER INTRAMUSCULARLY ONCE A MONTH	1	_____
	☐ 22.5mg KIT (3 MONTH SUPPLY)	ADMINISTER INTRAMUSCULARLY EVERY 3 MONTH	1	_____
	☐ 30mg KIT (4MONTH SUPPLY)	ADMINISTER INTRAMUSCULARLY EVERY 4 MONTH	1	_____
	☐ 45mg KIT (6 MONTH SUPPLY)	ADMINISTER INTRAMUSCULARLY EVERY 6 MONTH	1	_____
☐ NILANDRON	150mg TABLETS		_____	_____
☐ XGEVA	120mg/1.7ML VIAL		_____	_____
☐ ZOLADEX	☐ 3.6mg IMPLANT SYRINGE (1 MONTH SUPPLY)		_____	_____
	☐ 10.8mg IMPLANT SYRINGE (3 MONTH SUPPLY)		_____	_____
☐ ZYTIGA	☐ 250mg TABLETS	TAKE 4 TABLETS (1000mg) BY MOUTH ONCE DAILY ON AN EMPTY STOMACH	120	_____
	☐ 500mg TABLETS	TAKE 2 TABLETS (1000mg) BY MOUTH ONCE DAILY ON AN EMPTY STOMACH	60	_____
☐ METHYL-PREDNISOLONE	4mg TABLETS	TAKE 1 TABLET BY MOUTH TWICE DAILY WITH FOOD	_____	_____
☐ PREDNISONE	5mg TABLETS	TAKE 1 TABLET BY MOUTH TWICE DAILY WITH FOOD	60	_____
☐ OTHER			_____	_____

By signing this form and utilizing our services, you are authorizing TODT HILL PHARMACY and its employees to serve as your authorization designated agent in dealing with medical and prescription insurance companies

PRESCRIBER'S SIGNATURE (no stamp) SUBSTITUTION PERMITTED _____ DATE _____

PRESCRIBER'S SIGNATURE (no stamp) DISPENSE AS WRITTEN _____ DATE _____