MedBox

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UROLOGY FORM

Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

1: Patient Information

Patient Name: _____ Birthdate: ____ ____ _____ Sex: ◯Male ◯Female Height: _____ Weight: _____ ◯lbs. ◯kg.

Soc. Sec. #: _____ Preferred Phone: ( ) _____ - _____ Known Allergies: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate Caregiver Name: _____ Preferred Phone: ( ) _____ - _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ DEA#: _____ NPI#: _____ Tax ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____ Phone: _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____ ICD-10: _____ Serum Creatinine: _____

Renal Dysfunction: ◯Yes ◯No Liver Dysfunction: ◯Yes ◯No H/H (Hemoglobin/Hematocrit): _____ _____

To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values/scans:

Date and value of last HbA1c _____ Date and value of last Serum PSA _____

Date and value of last Serum Testosterone _____

Date of Orchiectomy_____ / _____ / _____

Current GnRH antagonist therapy: ☐Lupron ☐Zoladex ☐Firmagon OR ☐bilateral orchiectomy

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Erlead™**	60 mg	Take 4 (60mg) tablets by mouth daily Give with a gonadotropin-releasing hormone (GnRH) analog if the patient		
☐ **Zytiga®**	250 mg	has not had a bilateral orchiectomy Take 4 tablets daily without food		
☐ With Prednisone	5mg	☐ 5mg BID with food ☐ Other:		
☐ **Xgeva®**				
☐ **Xtandi®**				
☐ **Casodex®**				
☐ **Eligard®**				
☐ **Lupron®**				
☐ **Nilandron®**				
☐ **Zoladex®**				
☐				
☐				
☐				

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: Date:

Prescriber Signature: Prescriber, please sign and date below

Dispense as written Date Substitution Permissable Date

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____

1SmbQSYC

By signing below, I hereby authorize MedBox Specialty pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.