TruCare PHARMACY
Phone: (844) 446-0808 | Fax: (844) 446-0809

UROLOGY PRESCRIPTION FORM

Ship To: ☐ Patient ☐ Physician
☐ Pick-up (store location)

Patient Information			Physician Information	
Patient Name (Required):			Physician Name:	
Home Phone:	Cell Phone:		LIC#:	DEA #:
Address:			NPI #:	Specialty:
City:	State:	Zip:	Practice Name/Hospital:	
Emergency Contact Name & Phone #:			Address:	
Patient SS#:	Allergies: ☐ NKA		City: State: Zip:	
DOB (Required):	Sex: ☐ M ☐ F	Weight: ☐ lbs. ☐ Kg	Physician's Phone:	Physician's Fax:
☐ **See attached demographic sheet**	Height:	BSA:	Nurse/Key Office Contact:	

INSURANCE INFORMATION | Please Complete or Attach Copies (front and back) of cards

Primary Ins:	Secondary Ins:	Rx Card (PBM):	Card Holder First Name:
City: State:	City: State:	PBM BIN:	Last Name:
Plan #:	Plan #:	City: State:	Employer:
Group #:	Group #:	Group #:	ID#:
Phone: ( )	Phone: ( )	Phone: ( )	Group #:

DIAGNOSIS INFORMATION (choose one) | Please FAX clinical notes, Labs, Tests with the prescription

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 ________/ ________/________

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ **ZYTIGA®**	250mg	Take 4 tablets daily without food		
☐ **ZYTIGA® with Prednisone**	5mg	☐ 5mg BID with food		
		☐ Other: ______________________		
☐ **XGEVA®**				
☐ **XTANDI®**				
☐ **CASODEX®**				
☐ **ELIGARD®**				
☐ **LUPRON®**				
☐ **NILANDRON®**				
☐ **ZOLADEX®**				
☐ **OTHER**				

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in pharmaceutical company assisted patient support program

Patient Signature: ______________________ Date: ______________________

# of Medications Prescribed: ___________

Physician's Signature: ______________________ ☐ DAW (Dispense as Written) **Date:** ______________________

Prescriber certifies that this prescription form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Faxed prescription will only be accepted from a prescribing practioner. Prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Pursuant to OH/MO/VT law, only 1 medication is permitted per order form. Prescribers are reminded patients may choose any pharmacy of their choice. tcv11416