

Urology

Patient information	Prescriber + shipping information
Patient Name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SS #: _____ 1° Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate Phone: _____ Caregiver name: _____ Relation: _____ Local Pharmacy: _____ Phone: _____ Insurance Plan: _____ Plan ID # _____ Please fax a copy of front and back of the insurance card(s).	Prescriber Name: _____ NPI #: _____ Address: _____ Apt/Suite # _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email address: _____ If shipping to prescriber: <input type="checkbox"/> 1st Month <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical information (Please fax all pertinent clinical and lab information)

Diagnosis/ICD-10: _____ Any prior treatment: No Yes (provide information below)

Prior Therapy	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prescription information

<input type="checkbox"/> Casodex®	Take one 50 mg tablet by mouth once daily Qty: 30 tablets	Refill: _____
<input type="checkbox"/> Lupron Depot®	Inject 1 PFS intramuscularly <input type="checkbox"/> 7.5 mg once every month <input type="checkbox"/> 22.5 mg once every 3 months <input type="checkbox"/> 30 mg once every 4 months <input type="checkbox"/> 45 mg once every 6 months Qty: 1 kit	Refill: _____
<input type="checkbox"/> Xtandi®	Take four 40 mg capsules by mouth once daily Qty: 120 capsules	Refill: _____
<input type="checkbox"/> Zytiga® with prednisone	Take four 250 mg tablets once daily without food Qty: 120 tablets Take one 5 mg tablet twice daily with food Qty: 60 tablets	Refill: _____ Refill: _____
<input type="checkbox"/> _____	Strength: _____ Qty: _____ Directions: _____	Refill: _____

Support Medications

<input type="checkbox"/> Aranesp® <input type="checkbox"/> Arixtra® <input type="checkbox"/> Caphosol® <input type="checkbox"/> Emend® <input type="checkbox"/> Lovenox® <input type="checkbox"/> Neulasta®	<input type="checkbox"/> Neupogen® <input type="checkbox"/> Nplate® <input type="checkbox"/> Procrit® <input type="checkbox"/> Promacta® <input type="checkbox"/> Sancuso® <input type="checkbox"/> Zofran®	Strength: _____ Quantity: _____ Directions: _____ _____ Refill: _____ Packaging: <input type="checkbox"/> Normal <input type="checkbox"/> CarePak™ (if applicable) *Call for ordering procedure
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Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature: _____ Date: _____
I authorize Thrifty White Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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