

GREATER PLACER SPECIALTY PHARMACY

3133 PROFESSIONAL DRIVE #17 AUBURN, CA 95603
 PHONE: 530-885-8582 | FAX: 530-885-8593 OR 888-696-6055 | WWW.GPRX1.COM

Date: _____

UROLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: _____ Address: _____ City, State, Zip: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ SSN: _____ Phone: _____	Need by Date: _____ Ship to: <input type="checkbox"/> Patient Home <input type="checkbox"/> Other: _____
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PRESCRIBER INFORMATION

Prescriber Name: _____ Address: _____ City, State, Zip: _____	DEA: _____ Phone: _____ Contact Person: _____	NPI: _____ Fax: _____
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DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: _____ Date of Diagnosis/ Years with disease: _____ Serum Creatinine: _____ Allergies: _____
 Weight: _____ lbs / kg Height: _____ Date and value: Serum PSA: _____ Serum Testosterone: _____ HbA1c: _____

PRESCRIPTION INFORMATION

INITIAL PRESCRIPTION

PREVIOUSLY DISPENSED

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
<input type="checkbox"/> Casodex®	<input type="checkbox"/> 50mg			
<input type="checkbox"/> Lupron Depot®	<input type="checkbox"/> 7.5mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 30mg <input type="checkbox"/> 40mg <input type="checkbox"/>	Administer Intramuscularly ONCE every _____ MONTH (S)		
<input type="checkbox"/> Eligard®				
<input type="checkbox"/> Xgeva®				
<input type="checkbox"/> Nilandrone®				
<input type="checkbox"/> Zoladex®				

Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Greater Placer Pharmacy to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: _____ **Date:** _____ **Do not substitute**

Patient Support Programs:

By signing below, I authorize Greater Placer Pharmacy to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: _____ **Date:** _____

Important Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.