SMP PHARMACY SOLUTIONS

P: 855.650.5009
F: 855.447.6637

UROLOGY PRESCRIPTION FAXABLE

Today's Date: _____ Needed by: _____ Name: _____ Phone: _____

Patient Demographic: (Provide the following or attached demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Alt. Phone: _____
SS#: _____ Date Birth: _____
Gender: _____ Height: _____ Weight _____ BSA ____ m2

Prescriber: (Provide as much information as possible)

Prescriber's Name: _____ Group/Hospital: _____
Specialty: _____ NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Alt. Contact Name: _____
Phone: _____ Position: _____

Insurance Information (Please copy and attach the front and back of the Insurance Card):
Primary Insurance Name: _____ ID# _____ BIN#: _____ Group#: _____ PCN#: _____ Phone: _____
☐No Insurance ☐Patient will pay out of pocket ☐Enroll in Manufacturer's Patient Assistance Program

Medication Delivery to (Choose Only One):
☐Patient Address ☐First Fill Physician's Office, Refill to Patient Address ☐Patient will pick up at Pharmacy

Diagnosis (ICD -10 code): ☐ C61 Malignant Neoplasm of Prostate

Patient Allergies/ Allergic reactions:
1. _____ 2. _____

Prior (Failed) Medications (Reason for D/C):
1. _____ 2. _____

Medication	Dose	Direction	Quantity	Refills
Eligard	☐ 7.5mg ☐ 22.5mg ☐ 30mg ☐ 45mg	Inject Subcutaneously by Physician every _____ Month(s)		
Firmagon	☐ 240mg ☐ 80mg	☐ Loading Dose: 240mg SC X 1 ☐ Maintenance Dose: 80mg SC every 4 weeks		
Lupron	☐ 3.75mg ☐ 7.5mg ☐ 22.5mg ☐ 30mg ☐ 45mg	Inject Intramuscularly by Physician _____ Month(s)		
Trelstar	☐ 3.75mg ☐ 11.25mg ☐ 22.5mg	Inject Intramuscularly by Physician every _____ Month(s)		
Zoladex	☐ 3.6mg ☐ 10.8mg	_____ mg SC every _____ Month		
Other				
Other				

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

Prescriber Signature : _____ Date _____/_____/_____