



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. _____
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Medication	Dose	Direction	Quantity	Refills
Eligard	<input type="checkbox"/> 7.5mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 30mg <input type="checkbox"/> 45mg	Inject Subcutaneously by Physician every _____ Month(s)		
Firmagon	<input type="checkbox"/> 240mg <input type="checkbox"/> 80mg	<input type="checkbox"/> Loading Dose: 240mg SC X 1 <input type="checkbox"/> Maintenance Dose: 80mg SC every 4 weeks		
Lupron	<input type="checkbox"/> 3.75mg <input type="checkbox"/> 7.5mg <input type="checkbox"/> 22.5mg <input type="checkbox"/> 30mg <input type="checkbox"/> 45mg	Inject Intramuscularly by Physician _____ Month(s)		
Trelstar	<input type="checkbox"/> 3.75mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 22.5mg	Inject Intramuscularly by Physician every _____ Month(s)		
Zoladex	<input type="checkbox"/> 3.6mg <input type="checkbox"/> 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 _____/_____/_____

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