UROLOGY ORAL MEDICATIONS ENROLLMENT FORM

LINDEN RETAIL SPECIALTY PHARMACY

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SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name Address City, State, ZIP

Preferred Contact Methods Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone Alternate Phone Date of Birth Gender Male Female

Email Last Four of SSN Primary Language

2 PRESCRIBER INFORMATION

Prescriber's Name State License Number

NPI Number DEA Number Group or Hospital

Address City, State, ZIP

Phone Fax Contact Person Contact's Phone

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date Ship to Patient Office Other

Diagnosis (ICD-10):

C61 Prostate Cancer Other Code Description

Patient Clinical Information

Allergies Weight lb/kg Height in/cm

5 PRESCRIPTION INFORMATION

PRESCRIPTIONS	DRUG NAMES/STRENGHT	SIG/DIRECTIONS	QUANTITY/REFILLS
Erleada ™	60mg	4 tablets PO once daily #120 Other:	Quantity: Refills:
Xtandi®	40mg	4 capsules PO once daily #120 Other:	Quantity: Refills:
Zytiga®	250mg	4 tablets PO once daily #120 Other:	Quantity: Refills:
Prednisone	5mg	1 tablet PO twice daily #60 Other:	Quantity: Refills:
Other:	Other:	Other:	Quantity: Refills:

Patient is interested in patient support programs Ancillary supplies and kits provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

6 PYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED DATE DISPENSE AS WRITTEN DATE

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