Urology

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient information

Patient Name: _____ DOB: _____

Sex: ❑ Female ❑ Male SS #: _____

1˚ Language: _____ Wt:_____ ❑kg ❑lbs Ht:_____❑cm ❑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 + shipping information

Physician Name:_____

NPI #: _____

Address: _____

Apt/Suite # _____ City:_____ State:_____ Zip:_____

Contact: _____

Phone: _____ Alternate: _____

Fax: _____

Email address: _____

If shipping to physician: ❑ 1st Month ❑ Always ❑ 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

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

Support Medications

❑ Aranesp®	❑ Neupogen®	Strength: _____ Quantity: _____
❑ Arixtra®	❑ Nplate®*	Directions: _____
❑ Caphosol®	❑ Procrit®	_____
❑ Emend®	❑ Promacta®	_____
❑ Lovenox®	❑ Sancuso®	Refill: _____
❑ Neulasta®	❑ Zofran®	Packaging: ❑ Normal
		**Call for ordering procedure*

Prescription will be filled with generic (if available) unless prescriber writes "DAW" (dispense as written): _____

Prescriber's Signature:_____ Date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.