SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

Urology Enrollment Form
Patient Information

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed:_____ **Rx:** ☐ New ☐ Refill _____

Patient Information

Date:_____ Patient SS#: _____ **DIAGNOSIS DESCRIPTION:** _____ **ICD9 CODE:**_____

Patient's First Name: _____ Patient's Last Name:_____

Address:_____ City/County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone:_____

DOB: _____ Patient's Weight: _____ lbs. Recorded Date: _____

Allergies: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY:_____

Prescription

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Zytiga®**	☐ 250 mg tablet	☐ Take 4 tablets (1000 mg) by mouth once daily on an empty stomach, 1 hour before or 2 hours after eating.	#120	_____
☐ **Prednisone**	☐ 5 mg tablet	☐ Take 1 tablet by mouth twice daily with food ☐ Other:_____	☐ #60 ☐ #___	_____
☐ **Xtandi®**	☐ 40 mg tablet	☐ Take 4 capsules (160 mg) by mouth once daily	#120	_____
☐ **Lupron Depot®**	☐ 7.5 mg kit (1 month) ☐ 22.5 mg kit (3 month) ☐ 30 mg kit (4 month) ☐ 45 mg kit (6 month)	☐ Inject 7.5 mg IM once every month ☐ Inject 22.5 mg IM once every 3 months ☐ Inject 30 mg IM once every 4 months ☐ Inject 45 mg IM once every 6 months	#1	_____
☐ **Casodex**	☐ 50 mg tablet	☐ Take 1 tablet by mouth once daily	#30	_____

SUPPORT DRUGS

☐ Aranesp	☐ Emend	☐ Neupogen	☐ Promacta
☐ Arixtra	☐ Lovenox	☐ Nplate*	☐ Sancuso
☐ Caphosol	☐ Neulasta	☐ Procrit	☐ Zofran

Call for ordering procedure

DOSING & SIG:

Qty:_____ **Refill #:**_____

Complete this section ONLY if you would like SPS Pharmacy to initiate a Prior Authorization or Appeal on your behalf:

Previous Therapies

PRIOR THERAPY	REASON FOR DISCONTINUATION OF THERAPY	YEAR OF DISCONTINUATION
	☐ Disease Progression	_____
	☐ Finished Therapy	_____
	☐ Toxicity:_____	_____

Prescriber Information

Physician's Name (please print): _____ Contact Name: _____

Phone #: _____ Fax #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____