ST.JUDE SPECIALTY PHARMACY & MEDICAL SUPPLIES

UROLOGY PRESCRIPTION REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237
TEL: 718-381-5116 FAX: 718-417-3621
Proudly serving over 30 years

Date _____
☐ NEW PATIENT
☐ CURRENT PATIENT

ACCREDITED Specialty Pharmacy

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt #_____ City _____ State _____ Zip _____
Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy ICD-10 Code _____
Diagnosis _____ Serum Creatin _____ Renal Dysfunction ☐ Yes ☐ No Date of Orchiectomy _____
Date and value of last HbA1c _____ Date and value of last serum PSA _____ Date and value of last serum testosterone _____
To expedite prior authorization services, please provide Chemo regimen/schedule, last clinical notes and/or lab values /scans:

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City _____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

Medication	Dose/Strength	Directions	Qty.	Refills
Lupron Depot®				
Trelstar®				
Eligard®				
Firmagon®				
Casodex®				
Nilandron®				
Zoladex®				
Eulexin®				
Valstar®				
Mitomycin				
Xgeva®	120-mg dose (1.7-mL injection)	Administer once every 4 weeks		
Zytiga®	250 mg	Take 4 tablets daily without food		
With Prednisone	5mg	5mg BID with food Other:		

Notes: Please fax the insurance front and back

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____