DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

UROLOGY
REFERRAL FORM

Fax: **888.804.7717**

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

PATIENT INFORMATION

Patient's Full Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alt. Phone: _____

Patient SS#: _____ DOB: _____

Allergies: _____

Gender: ❑ Male ❑ Female

Diagnosis: _____ **ICD9 Code:** _____

Patient Weight: _____ Height: _____

Primary Insurance: _____

ID#: _____ Phone: _____

Secondary Insurance: _____

ID#: _____ Phone: _____

OR

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

DIAGNOSIS / CLINICAL INFORMATION

Serum Creatinine: _____

Renal Dysfunction: ❑ Yes ❑ No Liver Dysfunction: ❑ Yes ❑ No H/H (Hemoglobin/Hematocrit): _____

To expedite prior authorization services, please provide chemo regime/schedule, last clinical notes, and/or lab values/scans:

Date and value of last HbA1C: _____ Date and value of last Serum PSA: _____

Date and value of last serum Testosterone: _____ Date of Orchietomy: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY.	REFILLS
❑ Xtandi				
❑ Zytiga	250mg tablet	4 QD (on empty stomach)		
❑ Prednisone	5 mg tablet	BID w/ food		
❑ Casodex				
❑ Xgeva				
❑ Lupron Depot				
❑ Other				

PRESCRIBER INFORMATION

Physician's Name (Please Print): _____ NPI#: _____

Address: _____ License#: _____

City, State, Zip: _____ DEA#: _____

Phone: _____ Fax: _____ Contact Name: _____

Physician's Signature: _____ Date: _____

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.