US Bioservices
AmerisourceBergen

Urology Referral Form

Phone: (888) 518-7246
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: _____ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: _____

1. Patient Information

Last Name: _____ Home Phone: _____ Work / Mobile Phone: _____

First Name: _____ Home Address: _____

S.S. #: _____ Date of Birth: _____ City: _____ State: _____ Zip: _____

Guardian / Caregiver _____ Sex: ☐ Male ☐ Female Height: _____ Weight: _____ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: _____ Phone: _____ Prescription Card: _____ Phone: _____

Subscriber Name: _____ Policy #: _____ BIN / PCN: _____

Policy #: _____ Group #: _____ Medicare #: _____ Medicaid #: _____

3. Prescriber Information

Prescriber Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA License #: _____ NPI #: _____ DEA #: _____

Practice Name: _____ Phone: _____ Fax: _____

Address: _____ Office Contact: _____ Phone: _____

City: _____ State: _____ Zip: _____ Collaborating Physician: _____

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: _____ Secondary ICD-10: _____ Meds Tried / Failed: _____

Allergies: _____ Concurrent Medications: _____

Vaccination History: _____

5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
AFINITOR®	☐ 2.5 mg tabs ☐ 5 mg tabs ☐ 7.5 mg tabs ☐ 10 mg tabs			
ELIGARD®	☐ 7.5 mg kit ☐ 22.5 mg kit ☐ 30 mg kit ☐ 45 mg kit	• Inject _____ mg SC every _____ month(s)		
EMCYT®	☐ 140 mg caps			
ERLEADA®	☐ 60 mg tabs	• Take 4 tablets (240 mg) PO QD with or without food		
FIRMAGON®	☐ 80 mg kit ☐ 240 mg kit			
GLEEVEC®	☐ 100 mg tabs ☐ 400 mg tabs			
JEVTANA™	☐ 60 mg kit	• Take 4 tablets (240 mg) PO QD with or without food		
LUPRON DEPOT®	PFS: ☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg			
NEXAVAR®	☐ 200 mg tabs	• Take 2 tablets (400 mg) PO BID at least 1 hour before or 2 hours after eating		
NILANDRON®	☐ 150 mg tabs	• Take 300 mg PO QD for 30 days, and then 150 mg PO QD		
NUBEQA®	☐ 300 mg tabs	• Take 2 tablets (600 mg) PO BID with food		
SUTENT®	☐ 12.5 mg caps ☐ 37.5 mg caps ☐ 25 mg caps ☐ 50 mg caps			
TRELSTAR®	☐ 3.75 mg kit ☐ 11.25 mg kit ☐ 22.5 mg kit			
VANTAS®	☐ 50 mg kit			
XGEVA®	☐ 120 mg SDV			
XIAFLEX®	☐ 0.9 mg SDV ☐ 4 syringes	• Inject 0.58 mg into plaque of flaccid penis for 2 injections, 1-3 days apart		
XTANDI®	☐ 40 mg caps	• Take 160 mg PO QD		
YONSA	☐ 125 mg tablet	• Take 4 tablets (500 mg) PO QD in combination with methylprednisolone		
ZOLADEX®	PFS: ☐ 3.6 mg ☐ 10.8 mg			
ZYTIGA®	☐ 250 mg tabs ☐ 500 mg tabs			

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature _____ Date ____ / ____ / ____

Account Manager

_____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____

Prescriber Signature-Dispense as Written _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. Date ____ / ____ / ____