

PROSTATE REFERRAL FORM



PATIENT INFORMATION

Last Name	First Name	DOB
Gender	Last 4 SSN	Primary Language
Address		
City	State	ZIP
Email		
Home Phone	Work Phone	Cell Phone
Primary Contact Method (check one)	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Primary Caregiver <input type="checkbox"/> DO NOT CONTACT	
Primary Caregiver/Alt Contact Name (if applicable)		
Caregiver/Alt Contact Email	Caregiver/Alt Contact Phone	

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title
Preferred Contact Method (check one)	Referral Contact Email
<input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	
Office Phone	Office Fax
Practice / Facility Name	
Address	
City	State ZIP
Prescriber Name / Specialty	
Prescriber State License #	DEA #
NPI #	Medicaid UPIN #

INSURANCE INFORMATION

Insurance Provider	Plan ID #
BIN#:	PCN#:
Insured's Name	RX Group#:
	Relationship to Patient

Eligible for Medicare (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list Medicare #
Prescription Card (check one)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list carrier

Please include a copy of the front and back of insurance card.

CLINICAL INFORMATION

Patient New to Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date if Currently on Therapy	Date Medication Needed
Treatment History or Failed Therapies (Please also attach recent labs/clinical notes)		
Sample/Starter Product Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Provide Qty	Date Sample Provided
If Self-injectable drug, is injection training coordination required by our pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
PSA (ng/mL)	Date obtained	Family History of Prostate Cancer

Height (cm/in)	Weight (kg/lbs)	BSA	Date Obtained
Other/Concomitant Medications			
Ship to Address	<input type="checkbox"/> Home <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Other (please list)		
ICD-10 Codes	<input type="checkbox"/> C61 malignant neoplasm of prostate <input type="checkbox"/> D07.5 carcinoma in situ of prostate <input type="checkbox"/> D40.0 neoplasm of uncertain behavior of prostate <input type="checkbox"/> R97.1 elevated cancer antigen 125 <input type="checkbox"/> Z15.03 genetic susceptibility to malignant neoplasm of prostate <input type="checkbox"/> Z80.42 family history of malignant neoplasm of prostate <input type="checkbox"/> Z85.46 Personal history of malignant neoplasm of prostate <input type="checkbox"/> Other _____		

We accept Escribe and fax prescriptions.

