ACS Advanced Care Scripts

UroCare™ Therapy Referral Form

Phone: 877-985-MEDS(6337) **Fax: 866-679-7131**

Complete Patient Demographic Information in Section Below OR Attach Face Sheet from Patient Chart			
First Name:	*Middle Initial:*	*Last Name:*	
Date of Birth:	*Gender:* ☐ M ☐ F	*SSN:*	
Street Address:	City:	State:	Zip Code:
Home Phone:	*Work Phone:*	*Cell Phone:*	

Complete Patient Insurance Information in Section Below OR Attach Copies of Patient Insurance Card			
Insurance Carrier Name – Primary:	*Name of Insured:*		*Relationship:*
ID#:	*Group #:*		*Insurance Phone:*
Rx Carrier Name – Secondary:	*Rx ID#:*	*Rx Group #:*	*Rx Phone #:*

Complete Drug Therapy Information in Section Below OR Attach Completed Prescription

Drug Name	**Form/Strength/Directions for Use**	**Qty**	**Refills**
Zytiga (250mg tabs only)	☐ _____mg PO daily		
Eligard	☐ 7.5mg SC every 4 weeks ☐ 22.5mg SC every 12 weeks ☐ 30mg SC every 16 weeks ☐ 45mg SC every 24 weeks **Delivery to**: ☐ MD ☐ Patient		
Lupron-Depot	☐ 7.5mg IM every 4 weeks ☐ 22.5mg IM every 12 weeks ☐ 30mg IM every 16 weeks **Delivery to**: ☐ MD ☐ Patient		
Prednisone	☐_____ mg PO daily ☐ other _____		
Trelstar	☐ 3.75mg IM every 4 weeks ☐ 11.25mg IM every 12 weeks ☐ 22.5mg IM every 24 weeks **Delivery to**: ☐ MD ☐ Patient		
Xtandi (40mg tabs only)	☐ 160mg PO daily ☐ Other_____		
Zoladex	☐ 3.6 mg SC every 4 weeks ☐ 10.8 mg SC every 12 weeks **Delivery to**: ☐ MD ☐ Patient		
Casodex	☐ 50mg PO daily		
Other Medications	___Medication ___Direction		

Clinical Data			
Primary Diagnosis:	ICD-10:	*Weight:* pounds	*Height:* inches
Allergies: ___			
Failed Therapies: ___			
Current Therapies/Medications: ___			

Complete Prescriber Information in Section Below NOT Included on Attached Prescription				
MD First Name:		*MD Last Name:*		*DEA #:*
UPIN:	*State License #:*	*NPI:*		
Office Address:		City:	State:	Zip Code:
Office Phone:		*Office Fax:*		
Office Contact Name:		*Office E-mail:*		

SIGNATURE OF LICENSED PRESCRIBER IS REQUIRED TO VALIDATE PRESCRIPTIONS

☐ *I authorize Advanced Care Scripts to initiate a Prior Authorization on my behalf.* *TLC2/3/16*

Dr: ***NO Substitution Permitted***	**Dr:** ***Substitution Permitted***	**Date:**