aleracare
advanced specialty pharmacy

Urology
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Consideration

Diagnosis (ICD 10) :

- ○ C61 Malignant neoplasm of prostate
- ○ N40.1 Enlarged prostate with lower urinary tract symptoms
- ○ N13.8 Other obstructive and reflux uropathy
- ○ R33.9 Retention of urine, unspecified
- ○ R97.2 Elevated prostate specific antigen (PSA)
- ○ R35.0 Frequency of micturition
- ○ N39.0 Urinary tract infection, site unspecified
- ○ N39.41 Urge incontinence
- ○ N43.40 Spermatocele of epididymis, unspecified
- ○ N31.9 Neuromuscular dysfunction of bladder, unspecified
- ○ C67.9 Malignant neoplasm of bladder, unspecified
- ○ N20.1 Calculus of ureter
- ○ N20.2 Calculus of kidney with calculus of ureter
- ○ Other (please specify): _____

Medication	Dose	Directions for Use	Qty	Refills
○ **CASODEX®** (Bicalutamide)	○ 50mg tablet	○ 50mg PO every day at the same time		
○ **MITOMYCIN®**	○ 5mg IV ○ 20mg IV ○ 40mg IV			
○ **ELIGARD®** (Leuprolide)	○ 7.5mg Syr Kit ○ 22.5mg Syr Kit ○ 30mg Syr Kit ○ 45mg Syr Kit			
○ **LUPRON®** (Leuprolide)	○ 7.5mg Syr Kit ○ 22.5mg Syr Kit ○ 30mg Syr Kit ○ 45mg Syr Kit			
○ **ZOLADEX®** (Goserelin)	○ 3.6mg Implant Syr ○ 10.8mg Implant Syr			
○ **TRELSTAR®** (Triptorelin Pam)	○ 3.75mg Syr ○ 11.25mg Syr ○ 22.5mg Syr			
○ **ZYTIGA®** (Abiraterone)	○ 250mg Tablet ○ 500mg Tablet	○ 1000mg PO Q day		
○ **OTHER**				

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____