



VITAL CARE RX

Tailored Therapy, Trusted Care

Urology Enrollment Form
Phone: (877)229-1724 | Fax: (877)229-1725

PATIENT INFORMATION

(Complete the following or send patient demographic sheet.)
Please fax copy of patient's insurance card including both sides

Name: _____
DOB: _____ Gender: M / F Height: _____ Wt: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
Last 4 digits SS#: _____ Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State Lic. #: _____ NPI: _____
Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact: _____
Phone: _____ Email: _____

CLINICAL INFORMATION – STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____ ICD-10: _____ BSA: _____
Secondary Diagnosis/Treatment: _____
Allergies: _____
 New Restart Prior Therapies: _____

Medication	Directions	Quantity	Refills
AFINITOR®	<input type="checkbox"/> 2.5 mg tab <input type="checkbox"/> 5 mg tab <input type="checkbox"/> 7.5 mg tab <input type="checkbox"/> 10 mg tab		
ELIGARD®	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 45 mg <input type="checkbox"/> Inject _____ mg SC every _____ month(s)		
ERLEADA™	<input type="checkbox"/> 60 mg tab <input type="checkbox"/> Take 4 tablets (240mg) PO QD with or without food		
GLEEVEC®	<input type="checkbox"/> 100 mg tab <input type="checkbox"/> 400 mg tab		
LUPRON DEPOT®	<input type="checkbox"/> 7.5 mg PFS <input type="checkbox"/> 22.5 mg PFS <input type="checkbox"/> 30 mg PFS <input type="checkbox"/> 45 mg PFS		
NEXAVAR®	<input type="checkbox"/> 200 mg tab <input type="checkbox"/> Take 2 tablets (400mg) PO BID at least 1 hour before or 2 hours after eating		
NILANDRON®	<input type="checkbox"/> 150 mg tab <input type="checkbox"/> Take 300 mg PO QD for 30 days, and then 150 mg PO QD		
SUTENT®	<input type="checkbox"/> 12.5 mg <input type="checkbox"/> 37.5 mg <input type="checkbox"/> 25 mg <input type="checkbox"/> 50mg		
TRELSTAR®	<input type="checkbox"/> 3.75 mg Depo <input type="checkbox"/> 11.25 mg LA <input type="checkbox"/> 22.5 mg		
XGEVA®	<input type="checkbox"/> 120 mg/1.7 mL SDV		
XTANDI®	<input type="checkbox"/> 40 mg caps <input type="checkbox"/> Take 160 mg PO QD		
ZOLADEX®	<input type="checkbox"/> 3.6 mg <input type="checkbox"/> 10.8 mg		
ZYTIGA®	<input type="checkbox"/> 250 mg tab		
Other:			

Ship Medications To: Physician's Clinic Patient's Home

Injection Training Needed: Yes No

Prescriber Signature _____ Date _____ Brand Name Required? Yes

I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, financial treatment and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of this product to another pharmacy of the patient's choice or in the patient's insurer's provider network.