vitalcare SPECIALTY

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