LINCOLN PHARMACY

831 STERLING PARKWAY, SUITE #120, LINCOLN, CA 95648
PHONE: 916-209-3618 | FAX: 916-209-3634 | www.yourlincolnpharmacy.com

Date: __________

UROLOGY PRESCRIPTION FORM

PATIENT INFORMATION

Patient Name: ____
Address: ____
City, State,Zip: ____

☐ Male ☐ Female
Date of Birth: ____________________
SSN: ____________________
Phone: ____________________

Need by Date: ________________
Ship to: ☐ Patient Home
☐ Other: ______________

PRESCRIBER INFORMATION

Prescriber Name: ____
Address: ____
City, State, Zip: ____

DEA: ______________________________
Phone: ______________________________
Contact Person: ______________________

NPI: ________________________
Fax: ________________________

DIAGNOSIS/ CLINICAL INFORMATION

ICD-9 Code: __________ Date of Diagnosis/ Years with disease: __________ Serum Creatinine: __________ Allergies: ________________________________
Weight: _________lbs / kg Height: _________ Date and value: ☐ Serum PSA:__________ ☐ Serum Testosterone: _____________ ☐ HbA1c: _____________

PRESCRIPTION INFORMATION

☐ **INITIAL PRESCRIPTION** ☐ **PREVIOUSLY DISPENSED**

MEDICATIONS

MEDICATION	STRENGTH	DIRECTION	QTY	REFILLS
☐ Casodex®	☐ 50mg			
☐ Lupron Depot®	☐ 7.5mg ☐ 22.5mg ☐ 30mg ☐ 40mg ☐	Administer Intramuscularly ONCE every __________ MONTH (S)		
☐ Eligard®				
☐ Xgeva®				
☐ Nilandrone®				
☐ Zoladex®				

☐ Other medication:

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to **Lincoln Pharmacy** to act as the prescriber's agent to begin and execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature: ____ **Date:** ________________________ ☐ **Do not substitute**

Patient Support Programs:

By signing below, I authorize **Lincoln Pharmacy** to help me enroll in any or all patient co-pay assistance programs, including all foundations and manufacturer assistance programs. I authorize any communications among my providers, the pharmacy and the manufacturers regarding my health conditions and medications prescriptions in order to help coordinate the delivery of products and services through the various co-pay assistance programs. I understand that I may refuse to sign this form without affecting my ability to obtain treatment from the pharmacy. However, my refusal will not allow me to be enrolled in any co-pay assistance programs. If agreed, this signed authorization form (or a copy of this form) will be utilized as the original signed application for any and all possible foundations that may participate in the co-pay assistance programs, and it may serve such purpose.

Patient Signature: ____ **Date:** ________________________

Important Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that is protected under federal and state laws. If you are not the intended recipient, please notify the sender and destroy this document immediately.