Urology Enrollment Form

Please fax the completed form to

601-420-4040

Signature Care Program

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐ Patients Home ☐ Physician's Office ☐ Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION	
Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Adcirca®	☐ 40mg tablet	☐ Take once daily ☐ Other:	☐ 4 week supply ☐ Other:	
Afinitor®	☐ 2.5mg AFINITOR tablet ☐ 5mg AFINITOR tablet ☐ 7.5mg AFINITOR tablet ☐ 10mg AFINITOR tablet ☐ 2mg AFINITOR DISPERZ Oral Suspension ☐ 3mg AFINITOR DISPERZ Oral Suspension ☐ 5mg AFINITOR DISPERZ Oral Suspension	☐ Take once daily ☐ Other:	☐ 4 week supply ☐ Other:	

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Office Contact Name: _____ Preferred phone number & extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form to 601-420-4040