

# Urology Enrollment Form

Please fax the completed form to

**601-420-4040**



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: <input type="checkbox"/> Female <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
ICD-10 Code:	Medications failed:
Height: _____ feet _____ inches      Weight: _____ lbs.	Medications on:
Allergies:	Other notes:

**PRESCRIPTION INFORMATION**

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
<b>Adcirca®</b>	<input type="checkbox"/> 40mg tablet	<input type="checkbox"/> Take once daily <input type="checkbox"/> Other:	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<b>Afinitor®</b>	<input type="checkbox"/> 2.5mg AFINITOR tablet <input type="checkbox"/> 5mg AFINITOR tablet <input type="checkbox"/> 7.5mg AFINITOR tablet <input type="checkbox"/> 10mg AFINITOR tablet <input type="checkbox"/> 2mg AFINITOR DISPERZ Oral Suspension <input type="checkbox"/> 3mg AFINITOR DISPERZ Oral Suspension <input type="checkbox"/> 5mg AFINITOR DISPERZ Oral Suspension	<input type="checkbox"/> Take once daily <input type="checkbox"/> Other:	<input type="checkbox"/> 4 week supply <input type="checkbox"/> Other:	
<input type="checkbox"/> Patient is interested in patient support programs		<input type="checkbox"/> 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**

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