



valeda
HEALTH

UROLOGY Referral Form

Fax to: (844) ReferRx
733-3779

Faxed prescriptions will only be accepted from a prescribing practitioner.

Patients must bring an original prescription to the pharmacy.

Prescribers are reminded patients may choose any pharmacy of their choice.

Please contact your Valeda team if you have any questions and/or concerns at (844) 698-2533

Date Medication Needed: _____ Ship To: _____ Patient's Home _____ Prescriber's Office _____

1 Patient Information

Patient Name: _____ DOB: _____
Soc. Sec. #: _____ Email: _____
Home Phone: _____ Mobile Phone: _____ Preferred Phone: _____
Address: _____ Home / Mobile (circle one)
City: _____ State: _____ ZIP: _____

Alternate Caregiver Information

Alternate Caregiver Name: _____
Phone: _____ Email: _____

2 Prescriber Information

Provider Name: _____ NPI#: _____
Practice Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Tax ID#: _____
Phone: _____ Fax: _____

Practice Contact Information

Practice Contact: _____
Contact Phone: _____ Contact Email: _____

3 Clinical / Diagnosis Information

PLEASE FAX (1) Therapy regimen(s) / schedule, (2) last clinical notes and (3) lab values/scans -- (current and past)

Sex: Male Female Height: _____ Weight: _____ lbs. kg. (circle one)

Diagnosis: _____

ICD-10: (required for Medicare B billing) _____ BSA _____ m²

Renal Dysfunction: Yes No

Current SCr _____ or current GFR _____ ml/min

Liver Dysfunction: Yes No

Abnormal Lab Value(s) _____

H/H (Hemoglobin/Hematocrit): _____

Confirmed Mutations: EGFR ALK BRAF V600E BRAF V600K

CLL with 17p deletion Other: _____

Chemotherapy Regimen: _____

Known Allergies

Allergy: _____

Severity: _____ Rescue Medication? Yes / No (circle one)

4 Insurance Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

5 Prescription Information

STRENGTH / DIRECTIONS (SIG):

	Qty:	Refills:
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

Prescriber Signature: _____ Prescriber, please sign and date below

PHYSICIAN SIGNATURE REQUIRED

Dispense as written _____ Date _____ Substitution Permissible _____ Date _____

I authorize Valeda RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

of Prescriptions: _____