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: Home / Mobile (circle one)
Address: _____
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 _____ m^2
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.

# of Prescriptions: _____