

Rose Pharmacy
10008 Pines Blvd
Pembroke Pines, FL 33024
Phone: 954.432.8290
Fax: 844.246.3364



Representative:

Urology Order Form

Date Medication Needed: _____

Patient Information				
Last Name: _____		First Name: _____		
Date of Birth: _____	Social Security: _____		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address: _____		City: _____	State: _____	Zip: _____
Home Phone: _____		Cell Phone: _____		
Insurance: _____		Policy #: _____		*Please include copy of insurance card*
Clinical:				
Diagnosis/ICD-10 Code: _____		Ht / Wt / Allergies: _____		
Tried & Failed Medications: _____				
Rx Prescription:				
Medication	Dose/Strength	Directions	Quantity	Refills
TRELSTAR®	<input type="checkbox"/> Trelstar 3.75mg IM Every Month	Inject Intramuscularly by Physician		
	<input type="checkbox"/> Trelstar 11.25mg IM Every 3 months			
	<input type="checkbox"/> Trelstar 22.5mg IM Every 6 Months			
ELIGARD®	<input type="checkbox"/> Eligard 7.5mg Every Month	Inject Subcutaneously by Physician		
	<input type="checkbox"/> Eligard 22.5mg Every 3 Months			
	<input type="checkbox"/> Eligard 45mg Every 6 Months			
LUPRON®	<input type="checkbox"/> Lupron 7.5mg Every Month	Inject Intramuscularly by Physician		
	<input type="checkbox"/> Lupron 22.5mg Every 3 Months			
	<input type="checkbox"/> Lupron 30mg Every 4 Months			
	<input type="checkbox"/> Lupron 45mg Every 6 Months			
FIRMAGON®	<input type="checkbox"/> Firmagon (Starter Kit) 240mg	Starting: Treatment is started with a dose of 240mg given as two injections of 120mg each		
	<input type="checkbox"/> Firmagon (Maintenance) 80mg	Inject Subcutaneously every 28 days		
ERLEADA	<input type="checkbox"/> 60mg tablets <input type="checkbox"/> 240mg tablets	Take _____ tablets _____ times a day		
ZYTIGA	<input type="checkbox"/> 250mg tablets <input type="checkbox"/> 500mg tablets	Take _____ tablets _____ times a day		
ORGOVYX	<input type="checkbox"/> 120mg tablets	Take _____ tablets _____ times a day		
XGEVA®	<input type="checkbox"/> 120mg/1.7ml Vial	Inject 120mg IM Monthly		
PROLIA	<input type="checkbox"/> 60mg/ml PFS	Inject 60mg Subcutaneously every 6 months		
MITOMYCIN®	<input type="checkbox"/> 40mg vial	Inject 40mg into the bladder weekly for 6 weeks		
GEMCITABINE	<input type="checkbox"/> 2gm	Inject 2gm into the bladder weekly for 6 weeks		
OTHER:				

MD Signature (Required): _____ Date: _____

MD Name (Printed): _____ NPI: _____ DEA: _____

Phone: _____ Fax: _____ Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact us with questions at: info@rosenursing.net
or call **954.432.8290**

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.