ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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URAC ACCREDITED SPECIALTY PHARMACY

SPASSIST®
UROLOGY ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 10.31.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

www.commcarepharmacy.com

Plantation, FL
Phone: 888.203.7973
Fax: 888.203.7980
NCPDP: 1079638
NPI: 1598762015

URAC ACCREDITED SPECIALTY PHARMACY

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:__ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) □Patient's Address □Always to Physician's Office □First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis/ICD-10-CM Codes □_____ □_____ □_____ Date of Diagnosis: _____ OR Years with Disease:_____

Requested Clinical Information: *(as applicable – please send clinical notes)*
Height: _____ Weight: _____ BSA: _____m^2 PSA: _____
Cancer Stage: □Localized □Stage I □Stage II □Stage III □Stage IV □Other _____
Date and value of last Serum Testosterone _____

Previous Therapies:
Has patient been treated previously for this condition? ☐ Yes ☐ No (If yes, List Medications)
_____
_____

Ia. Urology/Oncology Medications:

□Afinitor® (everolimus)	□Erleada™ (apalutamide)	□Inlyta® (axitinib)	□Sutent® (sunitinib)
□Torisel® (temsirolimus)	□Votrient® (pazopanib)	□Xtandi® (enzalutamide)	□Zytiga® (abiraterone)
□Other:_____			□ with Prednisone

Dose & Directions *(please specify chemotherapy cycle days on / days off where applicable)*	**QUANTITY**	**REFILLS**

Ib. Additional Medications:

□Casodex® (bicalutamide)	□Eligard®(leuprolide)	□Eulexin (flutamide)	□Firmagon®(degarelix)
□Lupron Depot®(leuprolide)	□Nilandron® (nilutamide)	□Trelstar®(triptorelin)	□Vantas®(histrelin)
□Xgeva®(denosumab)	□Zoladex®(goserelin)	□Other:_____	

Dose & Directions *(please specify chemotherapy cycle days on / days off where applicable)*	**QUANTITY**	**REFILLS**

II. Supportive Medications:

Antiemetics: **(Please specify dosage form, dose and directions)** □Prochlorperazine □Ondansetron □Dolasetron □Emend® □Granisetron □Sancuso® □Akynzeo® □Other_____
Dose & Directions _____ Qty: _____Refill:_____

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to □Acro □Commcare

Physician Signature:_____ □DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ □ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program