



www.acropharmacy.com
 Sharon Hill, PA
 Phone: 800.906.7798
 Fax: 877.381.3806
 NCPDP: 3982902
 NPI: 1639103823



Memphis, TN
 Phone: 800.906.7798
 Fax: 844.612.9057
 NCPDP: 4447783
 NPI: 1518349562

SPASSIST[®]
UROLOGY

ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 10.31.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015



Patient Demographics: (Please provide the following or attach demographics sheet)		Provider Office: (Please provide as much information as possible)	
Patient Name: _____		Prescriber's Name: _____ Group/Hospital: _____	
Address: _____		Specialty: _____ License#: _____ Tax ID#: _____	
City, State, Zip: _____		Address: _____	
Preferred Phone: _____ Alt. Phone: _____		NPI: _____ DEA: _____	
Last four digits of SS#: _____ Date of Birth: _____		City, State, Zip: _____	
Gender: _____ Allergies: _____ Height: _____ Weight: _____		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: <input type="checkbox"/> Localized <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV <input type="checkbox"/> Other _____ Date and value of last Serum Testosterone _____	Previous Therapies: Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, List Medications) _____
---	--

Ia. Urology/Oncology Medications:

<input type="checkbox"/> Afinitor [®] (everolimus)	<input type="checkbox"/> Erleada [™] (apalutamide)	<input type="checkbox"/> Inlyta [®] (axitinib)	<input type="checkbox"/> Sutent [®] (sunitinib)
<input type="checkbox"/> Torisel [®] (temsirolimus)	<input type="checkbox"/> Votrient [®] (pazopanib)	<input type="checkbox"/> Xtandi [®] (enzalutamide)	<input type="checkbox"/> Zytiga [®] (abiraterone)
<input type="checkbox"/> Other: _____			<input type="checkbox"/> with Prednisone

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

Ib. Additional Medications:

<input type="checkbox"/> Casodex [®] (bicalutamide)	<input type="checkbox"/> Eligard [®] (leuprolide)	<input type="checkbox"/> Eulexin (flutamide)	<input type="checkbox"/> Firmagon [®] (degarelix)
<input type="checkbox"/> Lupron Depot [®] (leuprolide)	<input type="checkbox"/> Nilandron [®] (nilutamide)	<input type="checkbox"/> Trelstar [®] (triptorelin)	<input type="checkbox"/> Vantas [®] (histrelin)
<input type="checkbox"/> Xgeva [®] (denosumab)	<input type="checkbox"/> Zoladex [®] (goserelin)	<input type="checkbox"/> 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

CONFIDENTIALITY NOTICE: If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that you are not authorized to read, print, retain, copy or disseminate this message, any part of it, or any attachments. This facsimile message may contain information that is confidential, privileged, proprietary, or otherwise legally exempt from disclosure or use. **Any disclosure or use of this facsimile message by any person other than the intended recipient or person responsible for delivering it to the intended recipient may constitute a Federal criminal offense punishable by imprisonment up to 10 years or fines up to \$250,000.** If you have received this message in error, please destroy this message and any accompanying attachments in their entirety without reading the content and notify the sender immediately by telephone of the inadvertent transmission, by calling collect if located outside the calling area. There is no intent on the part of the sender to waive any right or privilege that may be attached to this communication. Thank you for your cooperation. *This prescription is valid only if transmitted by means of a facsimile machine from the authorized prescriber.