



Urology

Delivery Need By: [Deliver to: 🗆	Patient's Home	Physician's Offic	e 🗆 Other	
PATIENT INFORMATION PRESCRIBER INFORMATION						
Address: City: Phone Number: _ Email Address: Last Four of Soc	State: al: D0	D Female Zip: DB:	Office Contact Nar Address: City: Phone Number: DEA/NPI #:	State:	Zip: _ Fax:	
INSURANCE - PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK						
CLINICAL INFORMATION						
Diagnosis:			Has the patient been treated previously for this condition?			
ICD-10 Code:			□ Yes □ No			
Height: ft inches Weight: lbs Allergies:			Medications Failed: Medications On: Other Notes:			
PRESCRIPTION INFORMATION						
Medication:	Dosage/St	rength:		ctions:	Quantity:	Refills:
Medication: Afinitor*	Dosage/Str 2.5 mg tablet 5 mg tablet 7.5 mg tablet 10 mg tablet	rength:	Direc Take once daily Other	tions:	Quantity: 4 week supply 0 Other	Refills:
	□ 2.5 mg tablet □ 5 mg tablet □ 7.5 mg tablet	rength:	□ Take once daily	stions:	□ 4 week supply	Refills:
Afinitor®	 2.5 mg tablet 5 mg tablet 7.5 mg tablet 10 mg tablet 2 mg oral solution 3 mg oral solution 	rength:	 Take once daily Other Take once daily 	stions:	□ 4 week supply □ Other □ 4 week supply	Refills:
Afinitor® Afinitor Disperz®	 2.5 mg tablet 5 mg tablet 7.5 mg tablet 10 mg tablet 2 mg oral solution 3 mg oral solution 5 mg oral solution 2.5 mg 5 mg 10 mg 	rength:	 Take once daily Other Take once daily 	stions:	□ 4 week supply □ Other □ 4 week supply	Refills:
Afinitor® Afinitor Disperz® Tadalafil	 2.5 mg tablet 5 mg tablet 7.5 mg tablet 10 mg tablet 2 mg oral solution 3 mg oral solution 5 mg oral solution 2.5 mg 5 mg 10 mg 20 mg 25 mg 50 mg 	rength:	 Take once daily Other Take once daily 	stions:	□ 4 week supply □ Other □ 4 week supply	Refills:

Physician Signature:

Date: ___

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