

Phone: (888) 477-7080 • Fax: (844) 470-2480

## Prescription Information and Enrollment Form

Please see bottom of page for E-Prescribing instructions

### PATIENT INFORMATION (REQUIRED)

First Name:		Last Name:		Date of Birth:	
				Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Cell Phone:		Home Phone:		Email:	
Preferred Method of Contact: <input type="checkbox"/> Phone Call <input type="checkbox"/> Text <input type="checkbox"/> Email					
Address:			City:		State:
					Zip:

### PRESCRIBER INFORMATION (REQUIRED)

First Name:		Last Name:		NPI:	
Phone:		Fax:		Email:	
Address:			City:		State:
					Zip:
Prior Auth Coordinator:			Email:		
Phone:			Ext:	Fax:	

### PATIENT DIAGNOSIS (REQUIRED)

ICD-10 Code:		Allergies:	
Diagnosis:			
New to Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No, Start Date of Current Therapy: _____			

### PRESCRIPTION INFORMATION (REQUIRED)

<b>Rx: AVODART 5mg soft-gel capsules</b>		
Quantity:		90-Day Supply
		Refills:
Directions:		
Prescriber Signature:		Date:

### E-PRESCRIBE (PHARMACY LOOK-UP INFO)

Pharmacy:	ProCare Pharmacy Care
NPI:	1427160357
NCPDP:	1098121
Address:	2650 SW 145 <sup>th</sup> Ave, Miramar, FL 33027-6606

### OTHER METHODS OF SUBMITTING AN RX

Fax:	(844) 470-2480
Verbal:	(888) 477-7080