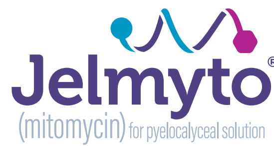
Patient Prescription Form for Department of Veterans Affairs (VA)

VA provider to complete the form and forward to the VA pharmacy.
VA pharmacy will fax or email the completed form to:
Fax: 833-664-7216 | Email: contact@UrogenSupport.com



Business Hours: 8 AM-8 PM ET M-F
833-UROGEN1 (833-876-4361)

* **Indicates a required field**

This form must be completed for the mixing and delivery of JELMYTO to the designated treatment site and is required only if mixing services are requested.

1 ENTER PATIENT INFORMATION — REQUIRED

First name:*	Last name:*
DOB:*	
Allergies:	Current medications:

2 PRESCRIPTION INFORMATION — REQUIRED

Instructions to Pharmacy (select all that apply)

- **6-Week Treatment Course:** Prepare one kit of JELMYTO 80 mg weekly according to JELMYTO Instructions for Pharmacy: For instillation via ureteral catheter or nephrostomy tube for 6 instillations. Refills: 8 (may dispense PRN for incomplete instillations).
- **Maintenance Course:** Prepare one kit of JELMYTO 80 mg monthly according to JELMYTO Instructions for Pharmacy: For instillation via ureteral catheter or nephrostomy tube. Refills: 12
- **Bilateral Disease/Second Kidney 6-Week Treatment Course:** Prepare one kit of JELMYTO 80 mg weekly according to JELMYTO Instructions for Pharmacy: For instillation via ureteral catheter or nephrostomy tube for 6 completed instillations. Refills: 8 (may dispense PRN for incomplete instillations).
- **Bilateral Disease/Second Kidney Maintenance Course:** Prepare one kit of JELMYTO 80 mg monthly according to JELMYTO Instructions for Pharmacy: For instillation via ureteral catheter or nephrostomy tube for 6 completed instillations. Refills: 12

Anticipated Treatment Date: _____/____/________

Prescribing Physician Signature
(Signature required; stamp not acceptable):*

Printed name:*	Date:*

3 PRESCRIBER INFORMATION (All fields required to be completed) — REQUIRED

Prescriber name:		
Prescriber address:		
City:	State:	Zip code:
Prescriber NPI number:		
State license number:	Phone number:	Fax number:
Email address:	Preferred method of contact: Phone Fax Email	

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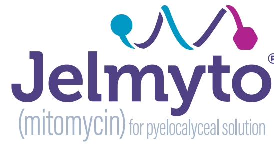

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4 VA PHARMACY INFORMATION (Medication will be shipped to the VA pharmacy) REQUIRED

VA name:			
Street address:	City:	State:	Zip code:
Phone number:	Fax number:	Email:	
Primary clinical contact first name:	Last name:		
Phone number:	Fax number:	Email:	
Secondary clinical contact first name:	Last name:		
Phone number:	Fax number:	Email:	

5 TREATMENT COORDINATION CONTACTS (Please provide important site of care information) REQUIRED

Contact name for patient treatment scheduling:	
Phone number:	Email (optional):

Forward completed form to the VA pharmacy. VA pharmacy will fax completed form to **833-664-7216** or email form to **contact@UrogenSupport.com**

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