Phone: 845-789-5648
Fax: 845-789-4104
NCPDP 5851476
NPI: 1457297335

LUPRON DEPOT REFERRAL FORM

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Diagnosis - Gynecology: ☐ **N80.**___ Endometriosis ☐ **D25.9** Uterine Fibroids ☐ Other _____
ICD-10 Diagnosis - Urology: ☐ Prostate Cancer _____ ☐ Other _____
ICD-10 Diagnosis - Pediatrics: ☐ **E30.1** Central Precocious Puberty ☐ Other _____
☐ New ☐ Restart ☐ Continuing Start Date:_____

PRESCRIPTION

ENDOMETRIOSIS ONLY

☐ **LUPANETA PACK 3.75 mg** (1-month supply) *Includes norethindrone acetate 5 mg tablets QTY 30* QTY: #1 kit Refills:_____
Sig: Administer Lupron IM once a month and take 1 norethindrone acetate tablet by mouth daily

☐ **LUPANETA PACK 11.25 mg** (3-month supply) *Includes norethindrone acetate 5 mg tablets QTY 90* QTY: #1 kit Refills:_____
Sig: Administer Lupron IM once every 3 months and take 1 norethindrone acetate tablet by mouth daily

ENDOMETRIOSIS AND/OR UTERINE FIBROIDS

☐ **LUPRON DEPOT 3.75 mg** (1-month supply) Sig: Administer IM once a month QTY: #1 kit Refills:_____
☐ **LUPRON DEPOT 11.25 mg** (3-month supply) Sig: Administer IM once every 3 months QTY: #1 kit Refills:_____
☐ **OTHER** _____ Sig: _____ QTY: #1 kit Refills:_____

ADVANCED PROSTATE CANCER

☐ **LUPRON DEPOT 7.5 mg** (1-month supply) Sig: Administer IM once a month QTY: #1 kit Refills:_____
☐ **LUPRON DEPOT 22.5 mg** (3-month supply) Sig: Administer IM once every 3 months QTY: #1 kit Refills:_____
☐ **LUPRON DEPOT 30 mg** (4-month supply) Sig: Administer IM once every 4 months QTY: #1 kit Refills:_____
☐ **LUPRON DEPOT 45 mg** (6-month supply) Sig: Administer IM once every 6 months QTY: #1 kit Refills:_____
☐ **OTHER:** _____ Sig: _____ QTY: #1 kit Refills:_____

IDIOPATHIC CENTRAL PRECOCIOUS PUBERTY

☐ **LUPRON DEPOT-PED 7.5 mg** (4 week supply) ☐ **11.25 mg** (4 week supply) ☐ **15 mg** (4 week supply)
Sig: Administer IM once a month (4 weeks) QTY: #1 kit Refills:_____

☐ **LUPRON DEPOT-PED 11.25 mg** (12 week supply)
Sig: Administer IM once every 3 months (12 weeks) QTY: #1 kit Refills:_____

☐ **LUPRON DEPOT-PED 30 mg** (12 week supply)
Sig: Administer IM once every 3 months (12 weeks) QTY: #1 kit Refills:_____

☐ **OTHER:** _____ Sig: _____ QTY: #1 kit Refills:_____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.
My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.