



**LUPRON DEPOT® (leuprolide acetate for depot suspension) and LUPANETA PACK™ (leuprolide acetate for depot suspension and norethindrone acetate tablets) REFERRAL FORM. SIGN AND FAX THIS FORM TO 877-314-8427. FOR QUESTIONS PLEASE CALL 888-857-0636.**

<b>REFERRAL TYPE</b>	<b>REFERRAL TYPE</b>	<b>COVERAGE TO INVESTIGATE (please select one)</b>
	<input type="checkbox"/> Dispense – Rx will be filled or forwarded <input type="checkbox"/> Non-dispense – Only a benefit verification will be performed	<input type="checkbox"/> Patient's prescription drug benefits <input type="checkbox"/> Physician buy-and-bill benefits

<b>PATIENT AND PRESCRIBER INFORMATION</b>	<b>PATIENT INFORMATION</b>	SSN (Last 4 ONLY) ____   ____   ____   ____	<b>PRESCRIBER INFORMATION</b>	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other: _____
	First Name: _____ MI: _____ Last Name: _____ DOB: _____ Weight (lbs): _____ Sex: Female Address: _____ City/State/Zip: _____ Primary Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M Alternate Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M Drug Allergies: _____	Prescriber Name: _____ Specialty: <input type="checkbox"/> Gyn <input type="checkbox"/> Other: _____ NPI/Provider #: _____ State License #: _____ Office Name: _____ Contact: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____		

<b>INSURANCE INFORMATION</b>	<b>Fax a copy of the front and back of prescription insurance card(s) or fill in the information below</b>			
	Primary Insurance: _____ Phone: _____ Cardholder ID #: _____ Group #: _____ PCN: _____ BIN: _____ Policyholder Name: _____ DOB: _____	Secondary Insurance: _____ Phone: _____ Cardholder ID #: _____ Group #: _____ PCN: _____ BIN: _____ Policyholder Name: _____ DOB: _____		

<b>CLINICAL AND PRESCRIPTION INFORMATION</b>	<b>DIAGNOSIS FOR WHICH LUPRON DEPOT IS BEING PRESCRIBED</b>	Date of Diagnosis: _____	
	<input type="checkbox"/> Endometriosis ICD-10: _____ <input type="checkbox"/> Fibroids ICD-10: _____ <input type="checkbox"/> Other ICD-10: _____		
	<b>LUPRON DEPOT/LUPANETA PACK PRESCRIPTION</b>	<input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing (Start Date): _____	
	<b>SHIPPING PREFERENCE</b>	Date needed: _____ <input type="checkbox"/> Deliver medication to the patient <input type="checkbox"/> Deliver medication to the prescriber	
	<b>Endometriosis and/or Uterine Fibroids</b>		
	<input type="checkbox"/> LUPRON DEPOT 3.75 mg (1-month supply) Sig: Administer IM once a month #1 kit Refills: _____ <input type="checkbox"/> LUPRON DEPOT 11.25 mg (3-month supply) Sig: Administer IM once every 3 months #1 kit Refills: _____ <input type="checkbox"/> Other _____ Sig: _____ Qty: _____ Refills: _____		
<b>Endometriosis ONLY</b>			
<input type="checkbox"/> LUPANETA PACK 3.75 mg (1-month supply) Includes norethindrone acetate 5 mg tablets #30 Sig: Administer Lupron IM once a month; take one norethindrone acetate tablet by mouth daily #1 kit Refills: _____ <input type="checkbox"/> LUPANETA PACK 11.25 mg (3-month supply) Includes norethindrone acetate 5 mg tablets #90 Sig: Administer Lupron IM once every 3 months; take one norethindrone acetate tablet by mouth daily #1 kit Refills: _____			
<b>Add-Back Therapy (For Lupron Depot—Endometriosis only) In states not permitting dual prescriptions, please fax a separate prescription</b>			
<input type="checkbox"/> Norethindrone acetate 5 mg tablet Sig: Take one tablet by mouth daily Qty: <input type="checkbox"/> 30 <input type="checkbox"/> 90 Other: _____ Refills: _____ <input type="checkbox"/> Norethindrone acetate 5 mg tablet Sig: _____ Qty: _____ Refills: _____			

**PRESCRIBER SIGNATURE:** PRESCRIBER MUST MANUALLY SIGN (RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER, AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED), OR SEND AN ELECTRONIC PRESCRIPTION TO PHARMACY SOLUTIONS, AN ABBVIE COMPANY.

<input type="checkbox"/> Dispense as written/Do not substitute	Date _____	<input type="checkbox"/> Substitution permitted/Brand exchange permitted	Date _____
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I authorize Pharmacy Solutions and its employees to serve as my agent for the sole purpose of obtaining patient benefit information and the necessary prior authorization forms when dealing with Health Plans and Pharmacy Benefits Managers (PBMs), if the plan or PBM requires such authorization.

For states requiring handwritten expressions of Product Selection, use this area (e.g., medically necessary, may not substitute, dispense as written, etc.)

The information contained in this communication is confidential and intended for the addressee. It may contain Protected Health Information (PHI) under HIPAA. PHI is personal and sensitive information related to a person's health. This information is sent to you under circumstances when a participant's authorization is not required. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure, unless permitted by law, is prohibited. If you are not the intended recipient, you are hereby notified that dissemination, disclosure, copying, or distribution of this information is strictly prohibited and may be unlawful. Please notify sender immediately to arrange for return of this document.

**Please see accompanying full Prescribing Information or visit [www.LupronD.com](http://www.LupronD.com) or [www.LupanetaPack.com](http://www.LupanetaPack.com).**