pharmacy | **SOLUTIONS**

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.

REFERRAL TYPE

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☐ Dispense – Rx will be filled or forwarded
☐ Non-dispense – Only a benefit verification will be performed

COVERAGE TO INVESTIGATE (please select one)

☐ Patient's prescription drug benefits
☐ Physician buy-and-bill benefits

PATIENT AND PRESCRIBER INFORMATION

PATIENT INFORMATION SSN (Last 4 ONLY) ____ | ____ | ____ | ____

First Name: _____ MI: _____
Last Name: _____
DOB: _____ Weight (lbs): _____ Sex: Female
Address: _____
City/State/Zip: _____
Primary Phone: _____ ☐ H ☐ W ☐ M
Alternate Phone: _____ ☐ H ☐ W ☐ M
Drug Allergies: _____

PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other: _____

Prescriber Name: _____
Specialty: ☐ Gyn ☐ Other: _____
NPI/Provider #: _____ State License #: _____
Office Name: _____
Contact: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

INSURANCE INFORMATION

Fax a copy of the front and back of prescription insurance card(s) or fill in the information below

Primary Insurance: _____
Phone: _____
Cardholder ID #: _____ Group #: _____
PCN: _____ BIN: _____
Policyholder Name: _____ DOB: _____

Secondary Insurance: _____
Phone: _____
Cardholder ID #: _____ Group #: _____
PCN: _____ BIN: _____
Policyholder Name: _____ DOB: _____

CLINICAL AND PRESCRIPTION INFORMATION

DIAGNOSIS FOR WHICH LUPRON DEPOT IS BEING PRESCRIBED Date of Diagnosis: _____

☐ Endometriosis ICD-10: _____ ☐ Fibroids ICD-10: _____ ☐ Other ICD-10: _____

LUPRON DEPOT/LUPANETA PACK PRESCRIPTION ☐ New ☐ Restart ☐ Continuing (Start Date): _____

SHIPPING PREFERENCE Date needed: _____ ☐ Deliver medication to the patient ☐ Deliver medication to the prescriber

Endometriosis and/or Uterine Fibroids

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

Endometriosis ONLY

☐ 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: _____
☐ 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: _____

Add-Back Therapy (For Lupron Depot—Endometriosis only) **In states not permitting dual prescriptions, please fax a separate prescription**

☐ Norethindrone acetate 5 mg tablet Sig: Take one tablet by mouth daily Qty: ☐ 30 ☐ 90 Other: _____ Refills: _____
☐ 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.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

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.)

Please see accompanying full Prescribing Information or visit www.LupronD.com or www.LupanetaPack.com.