

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	REFERRAL TYPE	COVERAGE TO INVESTIGATE (please select one)
	<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

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

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

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 or www.LupanetaPack.com.