RxCrossroads – An AbbVie HUB Service

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 1-866-867-0465. FOR QUESTIONS PLEASE CALL 1-855-587-7663

Patient Information		**Prescriber Information**
First Name:	MI:	Prescriber Name:
Last Name:		Specialty: ☐ GYN ☐ Other:
DOB:	Sex: Female	NPI:
Address:		State License Number:
City/State/Zip:		Office Name:
Primary Phone:	Cell ☐	Address:
Alternate Phone:	Cell ☐	City/State/Zip:
Drug Allergies:		Phone:
Primary Insurance:		Fax:
Phone:		**Office Contact Information:**
Cardholder ID:	Group#:	Office Contact Name:
PCN:	BIN:	Office Contact Phone Number:
Policy Holder Name:	DOB:	Office Contact Extension:
Secondary Insurance:		Office Contact Fax Number:
Phone:		Address:
Cardholder ID:	Group#:	City/State/Zip:
PCN:	BIN:	
Policy Holder Name:	DOB:	

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 prescriber ☐ Deliver medication to patient

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: _____

ENDOMETRIOSIS ONLY

☐ Lupaneta Pack 3.75 mg (1 month supply) 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) 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: _____

PLEASE VERIFY THE FOLLOWING BENEFITS:

☐ Patient's coverage through pharmacy benefits ☐ Patient's coverage through medical benefits ☐ Patient's coverage through Buy/Bill

☐ I DO NOT WANT LUPRON DEPOT OR LUPANETA PACK DISPENSED AT THIS TIME.

PRESCRIBER SIGNATURE: Prescriber must manually sign (rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted)

_____ _____

Dispense as written / Do not substitute Date Substitution permitted / Brand exchange permitted Date

I authorize RxCrossroads 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 click for accompanying full Prescribing Information for LUPRON DEPOT or LUPANETA PACK.