Lupron Depot/Eligard/Zoladex/Firmagon Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________________ DOB: ______________________
Address: ______________________________ City, State, ZIP Code: ______________________
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ______________________________ Alternate Phone: ______________________
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): ______________________________
Relationship to minor: ______________________
Email: ______________________ Last Four of SSN: ________ Primary Language: ______________

2 PRESCRIBER INFORMATION

Prescriber's Name: ☐ ______________ ☐ ______________ ☐ ______________ ☐ ______________
State License #: __________ NPI #: __________ DEA #: __________ Address: ______________________
City, State, ZIP Code: ______________________ Group or Hospital: ______________________
Phone: ______________ Fax______________ Contact Person: ______________ Contact's Phone: ______________

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______________________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________________

Diagnosis (ICD-10):

☐ C61 Malignant neoplasm of prostate ☐ Other Code: _____ Description: ______________________

Patient Clinical Information:

Allergies: ______________________ Height: _____in/cm Weight: _____lb/kg

©2022 CVS Specialty and/or one of its affiliates. 75-47192E 02/22/22

Lupron Depot/Eligard/Zoladex/Firmagon Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: ______________________________ Patient DOB: ______________________________

Prescriber Name: ______________________________ Prescriber Phone: ______________________________

5 PRESCRIPTION INFORMATION

Lupron Depot:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Lupron Depot 7.5 mg (1-month supply)	Administer IM once a month	Quantity: 1 kit Refills: __________
☐ Lupron Depot 22.5 mg (3-month supply)	Administer IM once every 3 months	Quantity: 1 kit Refills: __________
☐ Lupron Depot 30 mg (4-month supply)	Administer IM once every 4 months	Quantity: 1 kit Refills: __________
☐ Lupron Depot 4 5 mg (6-month supply)	Administer IM once every 6 months	Quantity: 1 kit Refills: __________
☐ Other: ____________________	Other: ________________________	Quantity: ________ Refills: __________

Eligard:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Eligard 7.5 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: __________
☐ Eligard Depot 22.5 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: __________
☐ Eligard Depot 30 mg (4-month supply)	Administer SC once every 4 months	Quantity: 1 kit Refills: __________
☐ Eligard 45 mg (6-month supply)	Administer SC once every 6 months	Quantity: 1 kit Refills: __________

Zoladex:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Zoladex 3.6 mg (1-month supply)	Administer SC once a month	Quantity: 1 kit Refills: __________
☐ Zoladex 10.8 mg (3-month supply)	Administer SC once every 3 months	Quantity: 1 kit Refills: __________

Firmagon:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Firmagon 120 mg/vial treatment pack (2 vials)	As an initial dose, administer 240 mg SC as two injections of 120mg each	Quantity: 1 kit Refills: __________
☐ Firmagon 80 mg/vial	Administer 80 mg SC every 28 days	Quantity: 1 kit Refills: __________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ____________________ **Date:** ________	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ____________________ **Date:** ________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.

©2022 CVS Specialty and/or one of its affiliates. 75-47192E 02/22/22