

Gynecology/Women's Health Lupron Depot 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

Diagnosis (ICD-10):

- | | |
|--|---|
| <input type="checkbox"/> N80.0 Endometriosis of uterus | <input type="checkbox"/> N80.1 Endometriosis of ovary |
| <input type="checkbox"/> N80.2 Endometriosis of fallopian tube | <input type="checkbox"/> N80.3 Endometriosis of pelvic peritoneum |
| <input type="checkbox"/> N80.4 Endometriosis of rectovaginal septum and vagina | <input type="checkbox"/> N80.5 Endometriosis of intestine |
| <input type="checkbox"/> N80.6 Endometriosis in cutaneous scar | <input type="checkbox"/> N80.8 Other endometriosis |
| <input type="checkbox"/> N80.9 Endometriosis, unspecified | <input type="checkbox"/> Other Code: _____ Description: _____ |

Patient Clinical Information:

Allergies: _____

Height: _____ in/cm

Weight: _____ lb/kg

5 PRESCRIPTION INFORMATION

Endometriosis and/or Uterine Fibroids:

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Lupron Depot 3.75 mg (1-month supply)	Administered IM once a month.	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot 11.25 mg (3-month supply)	Administered IM once every 3 months.	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Other: _____	Other: _____	Quantity: _____ Refills: _____

Add-Back Therapy (for Lupron Depot – Endometriosis only):

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Norethindrone acetate 5 mg tablet	Take one tablet by mouth daily	Quantity: <input type="checkbox"/> 30 <input type="checkbox"/> 90 <input type="checkbox"/> Other: _____ Refills: _____
<input type="checkbox"/> Norethindrone acetate 5 mg tablet	Other: _____	Quantity: _____ 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.

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