PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Lupron Depot - Referral Form

Send your RX to: (Select Location - optional)

Date Medication Needed: _____ Injection training by pharmacy? ☐

Ship to: ☐ Patient's Home ☐ Prescriber's Office Pick-up (store location): _____

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical)

Patient Name: _____ Gender: ☐ Male ☐ Female
Height: _____ Weight: _____ ☐ lbs. ☐ kg. SS#: _____ Birth Date: _____
Preferred Phone: _____ Known Allergies: _____
Address: _____ City: _____ State: _____ ZIP: _____
Insurance Info: _____ Policy Number: _____

2. PRESCRIBER INFORMATION

Provider Name: _____ DEA#: _____ NPI#: _____ TAX ID#: _____
Address: _____ Phone: _____ Fax: _____
City: _____ State: ____ ZIP: _____ Key Contact: _____ Phone #: _____
Specialty: ☐ Oncology ☐ Endocrinology ☐ Endocrinology - Peds Other: _____

3. CLINICAL INFORMATION

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Has patient previously been treated for this condition? ☐ Yes ☐ No
Is patient currently on therapy? ☐ Yes ☐ No
Current medications: _____
Will patient stop taking the above medication(s) before the new medication? ☐ Yes ☐ No

DIAGNOSIS:

☐ Malignant Neoplasm of prostate (ICD-10): _____ ☐ Endometriosis (ICD-10): _____
☐ Anemia – uterine leiomyoma (Fibroid), preoperatively with iron therapy (ICD-10): _____
Other: _____ (ICD-10): _____

4. PATIENT MEDICAL HISTORY

☐ DM ☐ CHF ☐ QT prolongation ☐ Seizure or epilepsy ☐ Abnormal electrolytes
☐ CBC w. differential ☐ Testosterone level at baseline: _____ ☐ PSA level (___ng/ml)
☐ BG at baseline: _____ ☐ Total Cholesterols (___mg/dl)
Cardiac problems (please specify): _____ Other (please specify): _____

ALLERGIES

☐ GnRH ☐ GnRH agonist ☐ Lupron Depot Other (please specify): _____

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5. PRESCRIPTION INFORMATION

☐ Taken alone ☐ Taken in combination with **norethindrone acetate** (_____mg by mouth daily)

	DOSAGE AND FREQUENCY	REFILLS
☐	7.5mg IM once every 4 weeks injection kit	x_____☐ months ☐ weeks
☐	22.5mg IM every 12 weeks	x_____☐ months ☐ weeks
☐	30mg IM every 16 weeks	x_____☐ months ☐ weeks
☐	45mg IM every 24 weeks	x_____☐ months ☐ weeks
☐	3.75mg IM every 4 weeks for 6 months	x_____☐ months ☐ weeks
☐	11.25mg IM every 3 months for 1 dose	x_____☐ months ☐ weeks
☐	11.25mg IM every 3 months for 2 doses	x_____☐ months ☐ weeks
☐	3.75mg IM every month for up to 3 months (☐ In combination with iron)	x_____☐ months ☐ weeks
☐	11.25mg IM as a single injection (☐ In combination with iron)	x_____☐ months ☐ weeks
☐	Other: _____	x_____☐ months ☐ weeks

5. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____

Patient Signature Date

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to RE Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Faxed prescriptions will only be accepted from a prescribing practitioner.
Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions