



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

**Lupron Depot-PEDs - 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:**

Central precocious puberty- Peds (ICD-10): \_\_\_\_\_  Precocious puberty (ICD-10): \_\_\_\_\_  
 Disorder of puberty, unspecified (ICD-10): \_\_\_\_\_ Other: \_\_\_\_\_ (ICD-10): \_\_\_\_\_

**4. PATIENT MEDICAL HISTORY**

Seizure or epilepsy  Abnormal electrolytes  CBC w. differential  
 Testosterone level at baseline: \_\_\_\_\_  Estrogen level at baseline: \_\_\_\_\_  
 BG at baseline: \_\_\_\_\_  Total Cholesterols (\_\_\_mg/dl)  
 Cardiac problems (please specify): \_\_\_\_\_ Other (please specify): \_\_\_\_\_

**ALLERGIES**

GnRH  GnRH agonist  Lupron Depot  Other (please specify): \_\_\_\_\_

### 5. PATIENT SUPPORT PROGRAMS

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

DOSAGE AND FREQUENCY		REFILLS
<input type="checkbox"/>	Body weight ≤25kg 7.5mg IM PFS once every month	x _____ □ months
<input type="checkbox"/>	Body weight >25-7.5kg 11.25mg IM once every month	x _____ □ months
<input type="checkbox"/>	Body weight >37.5kg 15mg IM once every month	x _____ □ months
<input type="checkbox"/>	11.25mg IM PFS once every 12 weeks (3 months)	x _____ □ months
<input type="checkbox"/>	30mg IM PFS once every 12 weeks (3 months)	x _____ □ months
<input type="checkbox"/>	Other: _____	x _____ □ months

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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 Permissible

\_\_\_\_\_  
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