

Gynecology/Women's Health Lupron Depot Enrollment Form



Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: Male Female

Address: _____ City, State, ZIP Code: _____

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

Email: _____ Last Four of SSN: _____ Primary Language: _____

Parent/Caregiver/Guardian Name (Last, First): _____ Relationship to patient: _____

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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