Gynecology/Women's Health Lupron Depot Enrollment Form

CVS specialty®

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: _____ 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):

☐ N80.0 Endometriosis of uterus
☐ N80.1 Endometriosis of ovary
☐ N80.2 Endometriosis of fallopian tube
☐ N80.3 Endometriosis of pelvic peritoneum
☐ N80.4 Endometriosis of rectovaginal septum and vagina
☐ N80.5 Endometriosis of intestine
☐ N80.6 Endometriosis in cutaneous scar
☐ N80.8 Other endometriosis
☐ N80.9 Endometriosis, unspecified
☐ 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
☐ Lupron Depot 3.75 mg (1-month supply)	Administered IM once a month.	Quantity: 1 kit Refills: _____
☐ Lupron Depot 11.25 mg (3-month supply)	Administered IM once every 3 months.	Quantity: 1 kit Refills: _____
☐ Other: _____	Other: _____	Quantity: _____ Refills: _____

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

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Norethindrone acetate 5 mg tablet	Take one tablet by mouth daily	Quantity: ☐ 30 ☐ 90 ☐ Other: _____ Refills: _____
☐ 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.