# Lupron Depot/Eligard/Zoladex/Firmagon Enrollment Form

**Fax Referral To:** 1-888-280-1191 OR 787-759-4161
**Phone:** 1-888-280-1190 OR 787-759-4162
**Email Referral To:** Customer.ServiceFax@CVSHealth.com
**Address:** 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

**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

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____
**Diagnosis (ICD-10):**
☐ C61 Malignant neoplasm of prostate ☐ Other Code: _____ Description: _____
**Patient Clinical Information:**
Allergies: _____ Height: _____in/cm Weight: _____lb/kg

# Lupron Depot/Eligard/Zoladex/Firmagon Enrollment Form

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

**Lupron Depot:**

| MEDICATION/DOSE | DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Lupron Depot 7.5 mg (1-month supply) | Administer IM once a month | Quantity: 1 kit<br>Refills: _____ |
| ☐ Lupron Depot 22.5 mg (3-month supply) | Administer IM once every 3 months | Quantity: 1 kit<br>Refills: _____ |
| ☐ Lupron Depot 30 mg (4-month supply) | Administer IM once every 4 months | Quantity: 1 kit<br>Refills: _____ |
| ☐ Lupron Depot 4 5 mg (6-month supply) | Administer IM once every 6 months | Quantity: 1 kit<br>Refills: _____ |
| ☐ Other: _____ | Other: _____ | Quantity: _____<br>Refills: _____ |

**Eligard:**

| MEDICATION/DOSE | DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Eligard 7.5 mg (1-month supply) | Administer SC once a month | Quantity: 1 kit<br>Refills: _____ |
| ☐ Eligard Depot 22.5 mg (3-month supply) | Administer SC once every 3 months | Quantity: 1 kit<br>Refills: _____ |
| ☐ Eligard Depot 30 mg (4-month supply) | Administer SC once every 4 months | Quantity: 1 kit<br>Refills: _____ |
| ☐ Eligard 45 mg (6-month supply) | Administer SC once every 6 months | Quantity: 1 kit<br>Refills: _____ |

**Zoladex:**

| MEDICATION/DOSE | DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Zoladex 3.6 mg (1-month supply) | Administer SC once a month | Quantity: 1 kit<br>Refills: _____ |
| ☐ Zoladex 10.8 mg (3-month supply) | Administer SC once every 3 months | Quantity: 1 kit<br>Refills: _____ |

**Firmagon:**

| MEDICATION/DOSE | DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Firmagon 120 mg/vial treatment pack (2 vials) | As an initial dose, administer 240 mg SC as two injections of 120mg each | Quantity: 1 kit<br>Refills: _____ |
| ☐ Firmagon 80 mg/vial | Administer 80 mg SC every 28 days | Quantity: 1 kit<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.