

Gynecology/Women's Health Lupron Depot 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

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.
 CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty and/or one of its affiliates.
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