Pediatric 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: _____
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):

☐ Other Code: _____ Description: _____ ☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____ Height: _____in/cm Weight: _____lb/kg

5 PRESCRIPTION INFORMATION

Central Precocious Puberty

MEDICATION/DOSE	DIRECTIONS	QUANTITY/REFILLS
☐ Lupron Depot-Ped 7.5 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
☐ Lupron Depot-Ped 11.25 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
☐ Lupron Depot-Ped 15 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
☐ Lupron Depot-Ped 11.25 mg (12-week supply)	Administer IM once every 3 months (12 weeks)	Quantity: 1 kit Refills: _____
☐ Lupron Depot-Ped 30 mg (12-week supply)	Administer IM once every 3 months (12 weeks)	Quantity: 1 kit Refills: _____
☐ Other: _____	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.