Pediatric 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

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: ________
☐ Lupron Depot-Ped 45 mg (24-week supply)	Administer IM once every 6 months (24 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.

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. Patient 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.

©2024 CVS Specialty® and/or one of its affiliates 75-47192F 3/1/24