

# Pediatric Lupron Depot Enrollment Form



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

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
<input type="checkbox"/> Lupron Depot-Ped 7.5 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot-Ped 11.25 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot-Ped 15 mg (4-week supply)	Administer IM once a month (4 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot-Ped 11.25 mg (12-week supply)	Administer IM once every 3 months (12 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot-Ped 30 mg (12-week supply)	Administer IM once every 3 months (12 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> Lupron Depot-Ped 45 mg (24-week supply)	Administer IM once every 6 months (24 weeks)	Quantity: 1 kit Refills: _____
<input type="checkbox"/> 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 <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____	May Substitute / Product Selection Permitted / Substitution Permissible <b>Prescriber's Signature:</b> _____ <b>Date:</b> _____
<b>CA, MA, NC &amp; PR:</b> Interchange is mandated unless Prescriber writes the words "No Substitution" _____ <b>ATTN: New York and Iowa providers,</b> 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.

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