



Lupron Referral Form

Phone: (706) 849-4161

Fax: (706) 798-9683

<p>PATIENT INFORMATION (Complete or include demographic sheet)</p> <p>Patient Name: _____ DOB: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Primary Phone: _____</p> <p>Alternate Phone: _____ Gender: _____</p> <p>Email: _____</p> <p>SSN: _____</p> <p>Allergies: _____</p>	<p>PRESCRIBER INFORMATION</p> <p>Prescriber Name: _____</p> <p>State License #: _____ NPI#: _____</p> <p>DEA#: _____</p> <p>Organization: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____ Fax: _____</p> <p>Contact Person: _____ Tax ID: _____</p>
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INSURANCE INFORMATION: Please fax/scan the front and back of the insurance card

DIAGNOSIS AND CLINICAL INFORMATION (Please fax recent clinical notes, labs, tests supporting information to expedite prior authorization process)

Date of Diagnosis: _____ ICD10: _____

Endometriosis Fibroids Other: _____

Lupron Depot/Lupaneta Pack Prescription New Restart Continuation of Therapy
 Start date if continuation therapy: _____

Shipping Preference: Deliver to Patient Deliver to Office

Date Needed: _____

MEDICATION	DOSE/STRENGTH	SIG	QTY	REF
<input type="checkbox"/> Lupron Depot	<input type="checkbox"/> 3.75mg (1month supply) <input type="checkbox"/> 11.25mg (3 month supply)	<input type="checkbox"/> Administer IM once a month <input type="checkbox"/> Administer IM once every 3 months		
<input type="checkbox"/> Lupaneta Pack	<input type="checkbox"/> 3.75mg (1 month supply) <input type="checkbox"/> 11.25mg (3 month supply)	<input type="checkbox"/> Administer IM once a month. Take one norethindrone tablet by mouth daily <input type="checkbox"/> Administer Lupron IM once every 3 months. Take one norethindrone tablet by mouth daily		
<input type="checkbox"/> Norethindrone	<input type="checkbox"/> 5 mg tablet	<input type="checkbox"/> Take one tablet by mouth		

Patient Support Program: Please sign and date below to enroll in the pharmaceutical company assisted patient support programs and patient funding.

PATIENT SIGNATURE _____ Date: _____

****By signing this form and utilizing our services, you are authorizing Barney's Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.****

X _____

Dispense as written

X _____

Substitution Permitted