

CIGNA Specialty Pharmacy Services - Lupron® Fax Order Form



Please deliver by: _____

Requests received after 4 p.m. CT will begin processing the following business day.

Fax: 1.800.351.3616

Phone: 1.800.351.3606

Order #: _____ Referral Source Code: 652

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:	DATE OF BIRTH :	NAME:	
	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	DEA #:	NPI:
HEALTH CARE ID #:		ADDRESS: (Street/Suite #) (City) (State) (Zip Code)	
HOME PHONE:	ALT PHONE:	TELEPHONE:	FAX:
		*Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		*May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ADDRESS: (Street) (City) (State) (Zip Code)		SHIP MEDICATIONS TO: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is REQUIRED for scheduling delivery.	
ALLERGIES: <small>If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Specialty Pharmacy previously.</small>		HOME HEALTH SERVICES REQUIRED? <input type="checkbox"/> No <input type="checkbox"/> Yes	
		LOCAL HOME HEALTH AGENCY:	TELEPHONE:
PRESCRIPTION INFORMATION			
LUPRON DEPOT® - PEDIATRIC (Leuprolide Acetate - J1950)		LUPRON DEPOT® - for MALES (Leuprolide Acetate - J1950)	
4 week dosing			
(Recommended starting dose 0.3mg/kg/4 weeks)		Lupron Depot 7.5 mg	
Lupron Depot-PED 7.5 mg (For children ≤25kg)		<input type="checkbox"/> IM every month	
<input type="checkbox"/> IM every 4 weeks		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____		Lupron Depot 22.5 mg	
Lupron Depot-PED 11.25 mg (For children >25-37.5kg)		<input type="checkbox"/> IM every 3 months	
<input type="checkbox"/> IM every 4 weeks		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____		Lupron Depot 30 mg	
Lupron Depot-PED 15 mg PED (For children ≥37.5kg)		<input type="checkbox"/> IM every 4 months	
<input type="checkbox"/> IM every 4 weeks		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____		Lupron Depot 45 mg	
Qty: _____ Refills: _____		<input type="checkbox"/> IM every 6 months	
		<input type="checkbox"/> Other: _____	
3 month dosing		Qty: _____ Refills: _____	
Lupron Depot-PED 11.25mg PED (3 month)			
<input type="checkbox"/> IM every 3 months			
<input type="checkbox"/> Other: _____			
Lupron Depot-PED 30 mg PED (3 month)			
<input type="checkbox"/> IM every 3 months			
<input type="checkbox"/> Other: _____			
Qty: _____ Refills: _____			
PHYSICIAN'S PRINTED NAME:		DATE:	
PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)			

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PATIENT NAME:	HEALTH CARE ID #:	DATE OF BIRTH:
LUPRON DEPOT® - for FEMALES (Leuprolide Acetate - J1950)		
Lupron Depot 3.75 mg <input type="checkbox"/> IM every month <input type="checkbox"/> Other: _____ Lupron Depot 11.25 mg <input type="checkbox"/> IM every 3 months <input type="checkbox"/> Other: _____ Qty: _____ Refills: _____	If using Lupron Depot®, for diagnosis of Endometriosis do you want to use Add-back* therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Norethindrone Acetate 5mg Take one tablet daily for duration of Lupron® therapy. # Tablets: _____ X _____ Refills. <input type="checkbox"/> Other add-back therapy: _____ Drug: _____ Directions: _____ Qty: _____ Refills: _____ <small>*Add-Back Therapy has been studied to be <u>effective against bone loss</u> during Lupron therapy. Those patients receiving Add-Back Therapy <u>experience fewer hot flashes</u> which could lead to improved patient compliance and lead to treatment completion and enhanced successful outcomes. American College of Obstetrics and Gynecologists, ACOG Practice Bulletin, Number 51. Chronic Pelvic Pain. Obstet gynecol. 2004;103:589-605.</small>	
PHYSICIAN'S PRINTED NAME:		DATE:
PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)		
SUPPLIES NEEDED (if medication is to be administered in patient's home): <input type="checkbox"/> Swabs <input type="checkbox"/> Sharps Container		
Mark the Diagnosis: <input type="checkbox"/> Endometriosis = 617.9 (ICD-9) <input type="checkbox"/> Uterine Fibroids = 218.9 (ICD-9) <input type="checkbox"/> Prostate Cancer = 185 (ICD-9) <input type="checkbox"/> Precocious Puberty = 259.1 (ICD-9) <input type="checkbox"/> Other (List Diagnosis ICD-9): _____		
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:		
In order for a brand name product to be dispensed, the prescriber must handwrite " Brand Necessary " or " Brand Medically Necessary " on the prescription		

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