Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

LUPRON DEPOT® ENROLLMENT FORM

Today's Date: ____________________

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**____________ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No

All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: ____________________ ☐ Male ☐ Female DOB:____________________

Patient's First Name: ____________________ Patient's Last Name: ____________________

Address: ____________________ City: ____________________ State: ______ ZIP: ____________

Best Phone Number: ____________________ Alternate Phone Number: ____________________

Height:____________________ Weight: ____________ ☐ kgs. or ☐ lbs. Recorded Date: ____________________

Caregiver: ____________________ Caregiver Contact Number: ____________________

Allergies: ____

Store Preference (address): ____

Emergency Contact Name: ____________________ Emergency Contact Phone #: ____________________

Insurance Information: Please fax copy of insurance card (front + back)

Primary Insurance: ____________________ Phone: ____________________

Policy #: ____________________ Medicare Effective Date #: ____________________

Clinical Info.

Prostate Cancer ICD-10: ____

Endometriosis ICD-10 ____________________ Fibroids ICD-10 ____________________

Other (include code): ____________________ Date of Diagnosis: ____________________

LUPRON DEPOT PRESCRIPTION

☐ New to LUPRON DEPOT ☐ Restart ☐ Continuing (Start Date): ____________________

Prescription

Prostate Cancer	SIG	Qty	Refills
☐ LUPRON DEPOT 7.5 mg (1-month supply)	Administer IM once a month	#1 kit	
☐ LUPRON DEPOT 22.5 mg (3-month supply)	Administer IM once every 3 months	#1 kit	
☐ LUPRON DEPOT 30 mg (4-month supply)	Administer IM once every 4 months	#1 kit	
☐ LUPRON DEPOT 45 mg (6-month supply)	Administer IM once every 6 months	#1 kit	
Endometriosis	**SIG**	**Qty**	**Refills**
Endometriosis and/or Uterine Fibroids ☐ LUPRON DEPOT 3.75 mg (1-month supply)	Administer IM once a month	#1 kit	
☐ LUPRON DEPOT 11.25 mg (3-month supply)	Administer IM once every 3 months	#1 kit	
Endometriosis ONLY ☐ LUPANETA PACK 3.75 mg (1-month supply) Includes norethindrone acetate 5 mg tablets #30 take one norethindrone acetate tablet by mouth daily	Administer Lupron IM once a month	#1 kit	
☐ LUPANETA PACK 11.25 mg (3-month supply) Includes norethindrone acetate 5 mg tablets #90 take one norethindrone acetate tablet by mouth daily	Administer Lupron IM once every 3 months	#1 kit	
☐ Other			

Prescriber Information

Date Prescription Needed: ____

Physician Name (please print): ____________________ Contact Name: ____________________

Phone #: ____________________ Fax #:____________________ NPI #: ____________________

Office Address: ____________________ City: ____________ State: ______ ZIP: ____________

State License #: ____________________DEA #: ____________________Tax ID #:____________________

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: ____ **Date:** ____________________