BERGEN AVE DRUGS
Specialty Pharmacy

LUPRON DEPOT PRESCRIPTION REFERRAL FORM

745 Bergen Ave | Jersey City, NJ, 07306
Tel 201.521.0545 | Fax 201.521.0546

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name _____ SS#_____ DOB _____ Height _____ Weight _____ ☐ Male ☐ Female
Street Address _____ Apt # _____ City _____ State _____ Zip _____
Evening Tel _____ Cell _____ ☐ Text Message Allowed Email _____
Caregiver Name _____ Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

ICD-10 Diagnosis - Gynecology: ☐ Endometriosis N80.___ (please specify) ☐ Uterine Fibroids D25.9 ☐ Other _____
ICD-10 Diagnosis - Urology: ☐ Prostate Cancer _____ ☐ Other _____
ICD-10 Diagnosis - Pediatrics: ☐ Central Precocious Puberty E30.1 ☐ Other _____
☐ New ☐ Restart ☐ Continuing Start Date:_____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____
Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn#_____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
Street Address _____ Suite # _____ City_____ State _____ Zip _____
Tel _____ Fax _____ Email _____
License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

ENDOMETRIOSIS ONLY

☐ **LUPANETA PACK 3.75 mg** (1-month supply)
Includes norethindrone acetate 5 mg tablets QTY 30
Sig: Administer Lupron IM once a month and take 1 norethindrone acetate tablet by mouth daily

☐ **LUPANETA PACK 11.25 mg** (3-month supply)
Includes norethindrone acetate 5 mg tablets QTY 90
Sig: Administer Lupron IM once every 3 months and take 1 norethindrone acetate tablet by mouth daily

QTY: #1 kit Refills:_____

ENDOMETRIOSIS AND/OR UTERINE FIBROIDS

☐ **LUPRON DEPOT 3.75 mg** (1-month supply)
Sig: Administer IM once a month

☐ **LUPRON DEPOT 11.25 mg** (3-month supply)
Sig: Administer IM once every 3 months

☐ **OTHER** _____
Sig: _____

QTY: #1 kit Refills:_____

ADVANCED PROSTATE CANCER

☐ **LUPRON DEPOT 7.5 mg** (1-month supply)
Sig: Administer IM once a month

☐ **LUPRON DEPOT 22.5 mg** (3-month supply)
Sig: Administer IM once every 3 months

☐ **LUPRON DEPOT 30 mg** (4-month supply)
Sig: Administer IM once every 4 months

☐ **LUPRON DEPOT 45 mg** (6-month supply)
Sig: Administer IM once every 6 months

QTY: #1 kit Refills:_____

☐ **Other:** _____
Sig: _____
QTY: _____ Refills:_____

IDIOPATHIC CENTRAL PRECOCIOUS PUBERTY

☐ **LUPRON DEPOT-PED 7.5 mg** (4 wk supply) ☐ **11.25 mg** (4 wk supply) ☐ **15 mg** (4 wk supply)
Sig: Administer IM once a month (4 weeks) QTY: #1 kit Refills:_____

☐ **LUPRON DEPOT-PED 11.25 mg** (12 wk supply) Sig: Administer IM once every 3 months (12 wks) QTY: #1 kit Refills:_____

☐ **LUPRON DEPOT-PED 30 mg** (12 wk supply) Sig: Administer IM once every 3 months (12 wks) QTY: #1 kit Refills:_____

☐ **OTHER:** _____ Sig: _____ QTY: #1 kit Refills:_____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

Please fax completed form to **Bergen** at **201.521.0546**

Visit us at **WWW.BERGENDRUGS.COM** for online fillable forms.