RxCrossroads – An AbbVie HUB Service

LUPRON DEPOT® (leuprolide acetate for depot suspension) and **LUPANETA PACK™** (leuprolide acetate for depot suspension and norethindrone acetate tablets) REFERRAL FORM.

SIGN AND FAX THIS FORM TO 866-867-0465. FOR QUESTIONS PLEASE CALL 855-587-7663

Patient Information		**Prescriber Information**
First Name:	MI:	Prescriber Name:
Last Name:		Specialty: GYN Other:
DOB:	Sex: Female	NPI:
Address:		Office Name:
City/State/Zip:		Address:
Primary Phone:		City/State/Zip:
Alternate Phone:		Phone:
Drug Allergies:		Fax:
Primary Insurance:		**Office Contact Information:**
Phone:		Office Contact Name:
Cardholder ID:	Group#	Office Contact Phone Number:
PCN:	BIN:	Office Contact Extension:
Policy Holder Name:	DOB:	Office Contact Fax Number:
Secondary Insurance:		Address:
Phone:		City/State/Zip:
Cardholder ID:	Group#:	
PCN:	BIN:	
Policy Holder Name:	DOB:	

DIAGNOSIS FOR WHICH LUPRON DEPOT IS BEING PRESCRIBED Date of Diagnosis: ______________

☐ Endometriosis ICD-10: ____________	☐ Fibroids ICD-10: ____________
☐ Other: __________ ICD-10: __________	LUPRON DEPOT/LUPANETA PACK PRESCRIPTION ☐ New ☐ Restart ☐ Continuing (Start Date: ________)

SHIPPING PREFERENCE Date Needed: ______________________

☐ Deliver medication to prescriber ☐ Deliver medication to patient

ENDOMETRIOSIS AND/OR UTERINE FIBROIDS

☐ Lupron Depot 3.75mg (1 month supply)	Sig: Administer IM once a month	#1 kit	Refills: _______
☐ Lupron Depot 11.25mg (3 month supply)	Sig: Administer IM once every 3 months	#1 kit	Refills: _______

ENDOMETRIOSIS ONLY

☐ Lupaneta Pack 3.75mg (1month supply)	Sig: Administer Lupron IM once a month, Take one Norethindrone tablet by mouth daily	#1 kit	Refills: ______
☐ Lupaneta Pack 11.25mg (3 month supply)	Sig: Administer Lupron IM once every 3 months, Take one Norethindrone Acetate tablet by mouth daily	#1 kit	Refills: _______

ADD-BACK THERAPY (For Lupron Depot - Endometriosis only) **In states not permitting dual prescriptions, please fax a separate prescription**

☐ Norethindrone acetate 5mg tablet Sig: Take one tablet by mouth daily Qty: ☐ 30 ☐ 90 Other: _______ Refills: _________

☐ Norethindrone acetate 5 mg tablet Sig: ____________________ Qty: _______________ Refills: _________

☐ PLEASE ONLY VERIFY THE FOLLOWING BENEFITS:

☐ Patient's coverage through pharmacies ☐ Patient's coverage through medical benefits ☐ Patient's coverage through Buy/Bill

☐ I DO NOT WANT LUPRON DEPOT OR LUPANETA PACK DISPENSED AT THIS TIME.

PRESCRIBER SIGNATURE: Prescriber must manually sign (rubber stamps, signature by other office personnel for the prescriber and computer-generated signatures will not be accepted)

Dispense as written / Do not substitute Date Substitution permitted / Brand exchange permitted Date

I authorize RxCrossroads and its employees to serve as my agent for the sole purpose of obtaining patient benefit information and the necessary prior authorization forms when dealing with Health Plans and Pharmacy Benefits Managers (PBMs),if the plan or PBM requires such authorization.

For states requiring handwritten expressions of Product Selection, use this area (e.g., medically necessary, many not substitute, dispense as written, etc.)

The information contained in this communication is confidential and intended for the addressee. It may contain Protected Health Information (PHI) under HIPAA. PHI is personal and sensitive information related to a person's health. This information is sent to you under circumstances when a participant's authorization is not required. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure, unless permitted by law, is prohibited. If you are not the intended recipient, you are hereby notified that dissemination, disclosure, copying, or distribution of this information is strictly prohibited and may be unlawful. Please notify sender immediately to arrange for return of

Please see Indications and Important Safety Information on pages 2 and 3. Please see full Prescribing Information provided or visit www.rxabbvie.com

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