LUPRON/LUPANETA REFERRAL FORM
Fax: 270-247-6033 or 270-251-3571

DUNCAN SPECIALTY PHARMACY

317 W. Broadway
Mayfield, KY 42066
Phone: 270-247-3725

Today's Date: Needs by Date: Ship to: ☐Patient ☐Office ☐Other:

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Home & Cell #:	DEA #: State Lic#:
SSN:	NPI#:
DOB: Sex:	Phone: Fax:
Drug Allergies:	Contact Person:

INSURANCE INFORMATION: Please fax front & back copy of Medical & Prescription card(s) if possible

Clinical Information—Statement Of Medical Necessity

Diagnostic Information & Prior Treatment History

Primary Diagnosis for which Lupron Depot is being prescribed: ☐ Endometriosis ICD-10: N80.9 ☐ Fibroids ICD-10: D25.9
Date of Diagnosis: ☐ Other: (Specify)

FOR LUPRON DEPOT PRESCRIPTIONS

☐ New to Lupron ☐ Restart ☐ Continuing
Start Date:

Prescription Information

MEDICATION	DIRECTIONS	QTY	REFILLS
ENDOMETRIOSIS & 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	
MEDICATION	**DIRECTIONS**	**QTY**	**REFILLS**
ADD-BACK THERAPY (ENDOMETRIOSIS ONLY)			
☐ Norethindrone Acetate 5mg Tablet	Take (1) tablet by mouth once a day	☐ 30 ☐ 90	
☐ Norethindrone Acetate 5 mg Tablet	Specify Directions:		
MEDICATION	**DIRECTIONS**	**QTY**	**REFILLS**
LUPANETA PACK PRESCRIPTION			
☐ Lupaneta Pack 3.75mg/5mg (1 month kit)	Administer IM once a month; Take 1 tablet by mouth once a day	1 pack	
☐ Lupaneta Pack 11.25mg/5mg (3 month kit)	Administer IM once every 3 months; Take 1 tablet by mouth once a day	1 pack	
MEDICATION	**DIRECTIONS**	**QTY**	**REFILLS**
OTHER MEDICATIONS			
☐			
☐			

By signing this form & utilizing our services, you are authorizing Duncan Specialty Pharmacy & its employees to serve as your prior authorization designated agent in dealing with medical & prescription insurance companies. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials to another pharmacy of the patient's choice or within his/her provider network.

Prescriber Signature: _____ Date: _____