Physician Replacement Request Form for Lupron®

Fax to Pharmacy Services at **855-811-9332**, or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

AmeriHealth Caritas District of Columbia

Patient Name: _____ Patient ID #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Birth date: _____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Drug: _____ Sig: _____

Physician Signature _____ Start date: _____ End date _____ OR Treatment dates _____

SECTION A. Please check the corresponding diagnosis and provide information accordingly:

☐ **Advanced Prostatic Cancer** ☐ **Advanced Breast Cancer**

☐ **Endometriosis (Please attach additional information if necessary)**

- Will the patient be receiving norethindrone acetate 5 mg in combination with Lupron to manage their condition? Yes ☐ No ☐ If NO Please explain:

  _____
- Has the patient had/already received ≥ 6 months of Lupron or GnRH therapy? Yes ☐ No ☐ **IF YES PLEASE COMPLETE SECTION B**
- If yes, please indicate why ≥ 6 months of treatment is warranted or attach additional information. _____

  _____

☐ **Uterine Leiomyomata (Fibroids) (Please attach additional information if necessary)**

- Did the patient receive iron therapy as a first line treatment to manage the condition Yes ☐ No ☐ If NO Please explain:

  _____
- Has the patient had ≥ 3 months of Lupron or GnRH therapy? Yes ☐ No ☐
- If yes please indicate why ≥ 3 months of treatment is warranted or attach additional information. _____

  _____
- Has the patient already received 6 months of cumulative Lupron or GnRH therapy? Yes ☐ No ☐ **IF YES PLEASE COMPLETE SECTION B**
- Is the patient receiving treatment for uterine fibroids, i.e. to decrease uterine volume to manage symptoms (pelvic pressure, urinary frequency, bleeding) and for shrinkage size to allow surgical intervention? Yes ☐ No ☐

☐ **Endometrial Thinning (for menorrhagia) (Please attach additional information if necessary)**

- Is the patient scheduled for an endometrial ablation for dysfunctional uterine bleeding? Yes ☐ No ☐
- If yes please comment _____

☐ **Central Precocious Puberty (CPP) (Please attach additional information if necessary)**

- Is there clinical diagnosis of CPP with onset of secondary sexual characteristics at less than age 8 in females and 9 in males? Yes ☐ No ☐
- Is diagnosis confirmed by a pubertal response to a GnRH stimulation test AND/OR measurement of gonadotropins (FSH/LH)? Yes ☐ No ☐
  - If yes please indicate or attach FSH/LH level lab results _____
- Is bone age 1 year > than chronological age? Yes ☐ No ☐ Bone age is _____
- Has the patient been evaluated to R/O tumors as a cause of CPP? Yes ☐ No ☐
- Is the child a male > 12 or a female > 11 years of age? Yes ☐ No ☐
- If yes please submit documented medical reason to continue treatment: _____

☐ **If Other Diagnosis please specify. (Please attach additional information if necessary)** _____

_____

SECTION B. Please provide the following information if patient has already received 6 months of cumulative therapy (Attach additional information if necessary)

- If yes, please submit DEXA scan results to evaluate patient's bone mineral density or indicate results (e.g. T score or Z score) _____

  _____
- Based on the DEXA scan does the patient have osteoporosis? Yes ☐ No ☐

  If yes please indicate what therapy the patient is receiving for treatment (e.g. Fosamax, Calcium plus Vitamin D) _____

  _____
- Is the patient receiving "add back" therapy (e. g. norethindrone acetate 5mg QD)? Yes ☐ No ☐

  If no, why _____

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