

Physician Request Form for Gonadotropin Releasing Hormone Agonists (GnRH) (i.e. Lupron Products)

Fax to Pharmacy Services at 888-981-5202, or to speak to a representative call 866-610-2774.

Form must be completed for processing.



Patient Name: _____ Member ID#: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Patient's Weight: _____ 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 _____

