

Prescription & Enrollment Form Lupron Depot®

(800) 962-6339 Office
(866) 755-6339 Fax



Patient Information

Last Name		First Name	
Social Security #		Date of Birth	
Parent or Guardian			
Home Phone		Other Contact Phone	
Home Address			
City, State, Zip			

Insured Information

Primary Insurance (Fax copy of card - both sides)	
Subscriber's Name	Relationship to Patient
Policy #	Group #
Primary Insurance Phone	
Prescription Card (Fax copy of card - both sides)	
Secondary Insurance	Policy #

DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnosis)

<input type="checkbox"/> 185 Prostate Cancer	<input type="checkbox"/> Other
<input type="checkbox"/> 218.9 Uterine Fibroids	Height _____ Weight _____
<input type="checkbox"/> 259.1 Precocious Puberty	Allergies:
<input type="checkbox"/> 617.9 Endometriosis	

PRESCRIPTION INFORMATION

Lupron Depot® <input type="checkbox"/> 3.75mg (1 month) <input type="checkbox"/> 11.25mg (3 month)	Directions:	Qty: Refills:
Lupron Depot® <input type="checkbox"/> 7.5mg (1 month) <input type="checkbox"/> 22.5mg (3 month) <input type="checkbox"/> 30.0mg (4 month)	Directions:	Qty: Refills:
Lupron Depot® <input type="checkbox"/> 7.5mg PED (1 month) <input type="checkbox"/> 11.25mg PED (1 month) <input type="checkbox"/> 15.0mg PED (1 month)	Directions:	Qty: Refills:

ADDITIONAL MEDICATION ORDERS FOR THIS PATIENT:

SUPPLIES NEEDED (if medication is to be administered in the patient's home):

If checked, please specify the size and type (if applicable):

- Syringes/Needles Swabs Sharps Container Other

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Patient's Home	<input type="checkbox"/> Other	Date Medication Needed:
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Physician's Name (Please Print) _____

Physician's Address _____

Phone _____ Fax _____

Dr.'s Office Contact Name _____

Physician's Signature _____ Date _____

Physician's DEA# _____

License # _____ NPI _____

Fax completed form to Medex BioCare (866) 755-6339