

Physician Replacement Request Form for Lupron®

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient Name: _____

Keystone Mercy 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)

- Was a diagnosis made via laparoscopy? Yes No
- Did the patient receive oral contraceptives and/or NSAIDs as a first line treatment to manage the condition, or does the patient have a documented medical reason for not receiving oral contraceptives and/or NSAIDs? Please explain _____

- Has the patient had ≥ 6 months of Lupron or Zoladex therapy? Yes No
- 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 oral contraceptives and/or NSAIDs as a first line treatment to manage the condition or does the patient have a documented medical reason for not receiving oral contraceptives and/or NSAIDs. Please explain _____

- Has the patient had ≥ 3 months of Lupron or Zoladex 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 Zoladex therapy? Yes No IF YES PLEASE COMPLETE SECTION B
- Is the patient receiving the drug solely for the management of anemia? (Hgb ≤ 10.2g/dl or Hct ≤ 30%) Yes No

- If yes please provide or attach the Hct and Hgb values _____
- Has the patient tried iron therapy prior to this? Yes No
- If yes, please indicate drug regimen _____

- 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 or soon to be prescribed "add back" therapy (e. g. norethindrone acetate 5mg QD or other hormone replacement therapy)? Yes No
- If yes, please indicate the treatment regimen _____