

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

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)

- 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