

Physician Request Form for Zoladex® or Lupron®

Fax non-urgent requests to PerformRx Pharmacy Services at 866-369-6041 or urgent requests to 866-533-5497. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 866-369-6037. Form must be completed for processing.



Patient Name: _____ Plan 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 _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) [] Yes [] No

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.
• Has the patient already received 6 months of cumulative Lupron or Zoladex therapy? Yes [] No [] IF YES PLEASE COMPLETE SECTION B
[] 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