

THIS FORM CAN BE USED TO REQUEST THE FOLLOWING SERVICES:

BENEFIT VERIFICATION • DISPENSING MEDICATION • FINANCIAL ASSISTANCE RESEARCH

Pharmacy Solutions, a specialty pharmacy service brought to you by AbbVie, provides expanded patient support and gives patients more options for accessing LUPRON DEPOT-PED® (leuprolide acetate for depot suspension) by providing the personalized support they need.

Insurance Support Services

- o Benefit verification and prior authorization assistance

Pharmacy Services

- o Medication dispensing and delivery coordination
- o Forwarding of the prescription to an in-network specialty pharmacy or patient-preferred pharmacy if Pharmacy Solutions is not in-network to dispense

Financial Assistance Research

- o AbbVie-sponsored co-pay card eligibility
- o Referrals to independent co-pay foundations or the AbbVie Patient Assistance Foundation

CHECKLIST FOR SUBMITTING FORM

1. Check the appropriate box above the Prescriber Signature section on the form if you do not want LUPRON DEPOT-PED to be dispensed at this time and are requesting benefit verification services.
2. Complete all sections of the form. Fax form to 800-266-2065.
3. Provide front and back copies of all insurance/prescription card(s).
4. Prescriber should sign in the designated area if writing a prescription for dispensing.
5. Fax form to (800) 266-2065.
6. If your state requires a prescription to be written on an official state prescription form (e.g., New York, New Jersey), please fax the prescription along with the LUPRON DEPOT-PED Referral Form.

Please provide complete information to ensure timely processing.

For more information, or to be connected with a dedicated Pharmacy Solutions Partner for your office, please call us at 888-857-0668.

Product support services are available regardless of where the prescription is filled.

Please see Indication and Important Safety Information on next page.
Please click here for [full Prescribing Information](#).

Indication for LUPRON DEPOT-PED® (leuprolide acetate for depot suspension)

LUPRON DEPOT-PED 7.5 mg, 11.25 mg, and 15 mg for 1-month and 11.25 mg and 30 mg for 3-month administration are indicated in the treatment of children with central precocious puberty (CPP).

CPP is defined as early onset of secondary sexual characteristics (generally earlier than 8 years of age in girls and 9 years of age in boys) associated with pubertal pituitary gonadotropin activation. It may show a significantly advanced bone age that can result in diminished adult height. Prior to initiation of treatment, confirm diagnosis of CPP by testing luteinizing hormone (LH) and sex steroid levels, and assess bone age versus chronological age. Baseline evaluations should be done to rule out intracranial tumor, steroid secreting tumors, a chorionic gonadotropin secreting tumor, and congenital adrenal hyperplasia.

Important Safety Information for LUPRON DEPOT-PED

LUPRON DEPOT-PED is contraindicated in:

- Patients with hypersensitivity to GnRH, GnRH agonist, or any of the excipients. Anaphylactic reactions to GnRH agonists have been reported in the medical literature.
- Females who are or may become pregnant during treatment, as it may cause fetal harm.

During the early phase of therapy, gonadotropins and sex steroids rise above baseline because of the initial stimulatory effect of the drug. An increase in clinical signs and symptoms of puberty may be observed.

Psychiatric events have been reported in patients taking GnRH agonists, including LUPRON DEPOT-PED. Events include emotional lability, such as crying, irritability, impatience, anger, and aggression. Monitor for development or worsening of psychiatric symptoms during treatment.

Postmarketing reports of convulsions have been observed in patients receiving GnRH agonists, including LUPRON DEPOT-PED. These included patients with a history of seizures, epilepsy, cerebrovascular disorders, central nervous system anomalies or tumors, and patients on concomitant medications that have been associated with convulsions, such as bupropion and SSRIs. Convulsions have also been reported in patients in the absence of any of the conditions mentioned above.

Monitor adequate response with a GnRHa stimulation test, basal LH, or serum concentration of sex steroid levels:

- After 1-2 months of initiating therapy for 1-month formulations
- After 2-3 months of initiating therapy and at month 6 for 3-month formulations
- For both formulations, ensure adequate suppression with each dose change or as judged clinically appropriate. Measure for height and bone advancement every 6-12 months

Noncompliance with drug regimen or inadequate dosing may result in inadequate control of the pubertal process with gonadotropins and/or sex steroids increasing above prepubertal levels.

The most common adverse reactions with GnRH agonists including LUPRON DEPOT-PED are injection site reactions/pain including abscess, general pain, headache, emotional lability, and hot flushes/sweating. The most frequent adverse reactions ($\geq 2\%$) in LUPRON DEPOT-PED clinical studies were:

- LUPRON DEPOT-PED 7.5 mg, 11.25 mg and 15 mg for 1-month administration: injection site reactions including abscess, emotional lability, acne/seborrhea, vaginitis/vaginal bleeding/vaginal discharge, pain, rash including erythema multiforme, headache, and vasodilation.
- LUPRON DEPOT-PED 11.25 mg, and 30 mg for 3-month administration: injection site pain, increased weight, headache, altered mood, and injection site swelling.

Diagnostic tests of pituitary gonadotropic and gonadal functions conducted during treatment and up to 6 months after discontinuation may be affected.

LUPRON DEPOT-PED must be administered under the supervision of a physician.

The use of LUPRON DEPOT-PED in children under 2 years of age is not recommended.

LUPRON DEPOT-PED® (leuprolide acetate for depot suspension) REFERRAL FORM

PLEASE COMPLETE THE ENTIRE FORM, THEN SIGN AND FAX THIS FORM TO 800-266-2065. FOR QUESTIONS PLEASE CALL 888-857-0668.

PATIENT AND PRESCRIBER INFORMATION	PATIENT INFORMATION SSN (Last 4 ONLY) ____ ____ ____ ____	PRESCRIBER INFORMATION <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other: _____
	First Name: _____ MI: _____	Prescriber Name: _____
	Last Name: _____	Specialty: <input type="checkbox"/> Endocrinologist <input type="checkbox"/> PCP <input type="checkbox"/> Other: _____
	DOB: _____ Weight (lbs): _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F	NPI/Provider #: _____ State License #: _____
	Address: _____	Office Name: _____
	City/State/Zip: _____	Contact: _____
	Primary Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	Address: _____
	Alternate Phone: _____ <input type="checkbox"/> H <input type="checkbox"/> W <input type="checkbox"/> M	City/State/Zip: _____
Drug Allergies: _____	Phone: _____ Fax: _____	

INSURANCE INFORMATION	Fax a copy of the front and back of prescription insurance card(s) or fill in the information below	
	Primary Insurance: _____	Secondary Insurance: _____
	Phone: _____	Phone: _____
	Cardholder ID #: _____ Group #: _____	Cardholder ID #: _____ Group #: _____
	PCN: _____ BIN: _____	PCN: _____ BIN: _____
	Policyholder Name: _____ DOB: _____	Policyholder Name: _____ DOB: _____

CLINICAL AND PRESCRIPTION INFORMATION	DIAGNOSIS FOR WHICH LUPRON DEPOT-PED IS BEING PRESCRIBED Date of Diagnosis: _____
	<input type="checkbox"/> Central Precocious Puberty ICD-10: _____ <input type="checkbox"/> Other (include code): _____
	LUPRON DEPOT PRESCRIPTION <input type="checkbox"/> New to LUPRON DEPOT-PED <input type="checkbox"/> Restart <input type="checkbox"/> Continuing (Start Date): _____
	SHIPPING PREFERENCE Date needed: _____ <input type="checkbox"/> Deliver medication to the patient <input type="checkbox"/> Deliver medication to the prescriber
	Idiopathic Central Precocious Puberty
	<input type="checkbox"/> LUPRON DEPOT-PED 7.5 mg (4 week supply) Sig: Administer IM once a month (4 weeks) #1 kit Refills: _____
	<input type="checkbox"/> LUPRON DEPOT-PED 11.25 mg (4 week supply) Sig: Administer IM once a month (4 weeks) #1 kit Refills: _____
	<input type="checkbox"/> LUPRON DEPOT-PED 15 mg (4 week supply) Sig: Administer IM once a month (4 weeks) #1 kit Refills: _____
	<input type="checkbox"/> LUPRON DEPOT-PED 11.25 mg (12 week supply) Sig: Administer IM once every 3 months (12 weeks) #1 kit Refills: _____
	<input type="checkbox"/> LUPRON DEPOT-PED 30 mg (12 week supply) Sig: Administer IM once every 3 months (12 weeks) #1 kit Refills: _____
<input type="checkbox"/> Other _____ Sig: _____ Qty: _____ Refills: _____	
<input type="checkbox"/> I DO NOT WANT LUPRON DEPOT-PED DISPENSED AT THIS TIME. PLEASE ONLY VERIFY THE FOLLOWING BENEFITS:	
<input type="checkbox"/> Patient's coverage through pharmacies <input type="checkbox"/> Patient's coverage through Buy/Bill	

PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN (RUBBER STAMPS, SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER, AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED), OR SEND AN ELECTRONIC PRESCRIPTION TO PHARMACY SOLUTIONS, AN ABBVIE COMPANY.

Dispense as written/Do not substitute **Date** **Substitution permitted/Brand exchange permitted** **Date**

I authorize Pharmacy Solutions and its employees to serve as my agent for the sole purpose of obtaining patient benefit information and the necessary prior authorization forms when dealing with Health Plans and Pharmacy Benefits Managers (PBMs), if the plan or PBM requires such authorization.

For states requiring handwritten expressions of Product Selection, use this area (e.g., medically necessary, may not substitute, dispense as written, etc.)

The information contained in this communication is confidential and intended for the addressee. It may contain Protected Health Information (PHI) under HIPAA. PHI is personal and sensitive information related to a person's health. This information is sent to you under circumstances when a participant's authorization is not required. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure, unless permitted by law, is prohibited. If you are not the intended recipient, you are hereby notified that dissemination, disclosure, copying, or distribution of this information is strictly prohibited and may be unlawful. Please notify sender immediately to arrange for return of this document.

Please see Indication and Important Safety Information on previous page.
Please click here for [full Prescribing Information](#).