pharmacy | SOLUTIONS

Bringing you LUPRON DEPOT® (leuprolide acetate for depot suspension)

Address: 1 North Waukegan Road,
AP5 NE, D-LP90
North Chicago, IL 60064
Phone: 888-857-0668
Fax: 800-266-2065

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® (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 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. 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 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.

An AbbVie Company

Indication for LUPRON DEPOT® (leuprolide acetate for depot suspension)[1]

LUPRON DEPOT® (leuprolide acetate for depot suspension) 7.5 mg for 1-month, 22.5 mg for 3-month, 30 mg for 4-month, and 45 mg for 6-month administration are indicated for the palliative treatment of advanced prostatic cancer.

LUPRON DEPOT is a gonadotropin-releasing hormone (GnRH) agonist administered as a single intramuscular injection under the supervision of a physician.

Important Safety Information for LUPRON DEPOT[1]

- LUPRON DEPOT is contraindicated in:
  - Patients with hypersensitivity to GnRH agonists or any of the excipients in LUPRON DEPOT.
  - Women who are or may become pregnant.
- LUPRON DEPOT causes an initial increase in serum testosterone (~50% above baseline) during the first few weeks of treatment. This initial increase can cause:
  - Transient worsening of symptoms, or additional signs and symptoms of prostate cancer.
  - Temporary increase in bone pain in a small number of patients, which can be managed symptomatically.
  - Isolated cases of ureteral obstruction and spinal cord compression, which may contribute to paralysis with or without fatal complications. Observe patients with vertebral metastasis and/or urinary tract obstruction closely.
- Periodic monitoring of serum testosterone and PSA levels is recommended.
- Hyperglycemia and increased risk of developing diabetes have been reported in men receiving GnRH agonists. Monitor blood glucose and/or glycosylated hemoglobin (HbA1c) periodically in men receiving a GnRH agonist, and manage hyperglycemia or diabetes.
- An increased risk of myocardial infarction, sudden cardiac death, and stroke has been reported in association with the use of GnRH agonists in men, although the risk appears low. Evaluate the risks carefully, including cardiovascular risk factors, when determining prostate cancer treatment. Patients receiving a GnRH agonist should be monitored for signs and symptoms of cardiovascular disease and managed appropriately.
- Androgen deprivation therapy (ADT) may prolong the QT/QTc interval. Consideration should be given to whether the benefits of ADT outweigh the potential risks in patients with congenital long QT syndrome, congestive heart failure, frequent electrolyte abnormalities, and in patients taking drugs known to prolong the QT interval. Correct electrolyte abnormalities and consider periodic monitoring of electrocardiograms and electrolytes.
- Postmarketing reports of convulsions have been observed in patients on leuprolide acetate therapy, including patients with a history of seizures, epilepsy, cerebrovascular disorders, central nervous system anomalies or tumors, and in patients on concomitant medications associated with convulsions, such as bupropion and SSRIs. Convulsions have also been reported in the absence of any of the conditions mentioned above.
- In controlled clinical trials of advanced prostatic cancer patients receiving LUPRON DEPOT, the following adverse events occurred in >10% of patients:
  - LUPRON DEPOT 7.5 mg for 1-month administration: hot flashes/sweats, general pain, edema, urinary disorders, GI disorders, and respiratory disorders.
  - LUPRON DEPOT 22.5 mg for 3-month administration: hot flashes/sweats, general pain, testicular atrophy, GI disorders, urinary disorders, injection site reactions, and joint disorders.
  - LUPRON DEPOT 30 mg for 4-month administration: hot flashes/sweats, injection site reactions, general pain, edema, urinary disorders, joint disorders, GI disorders, asthenia, flu syndrome, skin reactions, and headache.
  - LUPRON DEPOT 45 mg for 6-month administration: hot flush/flushing, upper respiratory tract infection/influenza-like illness, injection site pain/discomfort, and fatigue/lethargy.

Reference: 1. LUPRON DEPOT [package insert].

Please click here for full Prescribing Information.

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

SIGN AND FAX THIS FORM TO 800-266-2065. FOR QUESTIONS PLEASE CALL 888-857-0668.

REFERRAL TYPE

REFERRAL TYPE

☐ Dispense – Rx will be filled or forwarded

☐ Non-dispense – Only a benefit verification will be performed

COVERAGE TO INVESTIGATE (please select one)

☐ Patient's prescription drug benefits

☐ Physician buy-and-bill benefits

PATIENT AND PRESCRIBER INFORMATION

PATIENT INFORMATION SSN (Last 4 ONLY) ____ | ____ | ____ | ____

First Name: _____ MI: _____

Last Name: _____

DOB: _____ Weight (lbs): _____ Sex: ☐ M ☐ F

Address: _____

City/State/Zip: _____

Primary Phone: _____ ☐ H ☐ W ☐ M

Alternate Phone: _____ ☐ H ☐ W ☐ M

Drug Allergies: _____

PRESCRIBER INFORMATION ☐ MD ☐ DO ☐ Other: _____

Prescriber Name: _____

Specialty: ☐ Uro ☐ Other: _____

NPI/Provider #: _____ State License #: _____

Office Name: _____

Contact: _____

Address: _____

City/State/Zip: _____

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: _____

Phone: _____

Cardholder ID #: _____ Group #: _____

PCN: _____ BIN: _____

Policyholder Name: _____ DOB: _____

Secondary Insurance: _____

Phone: _____

Cardholder ID #: _____ Group #: _____

PCN: _____ BIN: _____

Policyholder Name: _____ DOB: _____

CLINICAL AND PRESCRIPTION INFORMATION

DIAGNOSIS FOR WHICH LUPRON DEPOT IS BEING PRESCRIBED Date of Diagnosis: _____

☐ Prostate Cancer ICD-10: _____ ☐ Other (include code): _____

LUPRON DEPOT PRESCRIPTION ☐ New to LUPRON DEPOT ☐ Restart ☐ Continuing (Start Date): _____

SHIPPING PREFERENCE Date needed: _____ ☐ Deliver medication to the patient ☐ Deliver medication to the prescriber

Advanced Prostate Cancer

☐ LUPRON DEPOT 7.5 mg (1-month supply)	Sig: Administer IM once a month	#1 kit	Refills: _____
☐ LUPRON DEPOT 22.5 mg (3-month supply)	Sig: Administer IM once every 3 months	#1 kit	Refills: _____
☐ LUPRON DEPOT 30 mg (4-month supply)	Sig: Administer IM once every 4 months	#1 kit	Refills: _____
☐ LUPRON DEPOT 45 mg (6-month supply)	Sig: Administer IM once every 6 months	#1 kit	Refills: _____
☐ Other _____	Sig: _____	Qty: _____	Refills: _____

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.)

Please see Indication and Important Safety Information on previous page.

Please click here for full Prescribing Information.