



LUPRON DEPOT REQUEST FORM
(when ordered from TapCare)

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID # _____

BIRTHDATE _____

Medicare Primary: (check one) Yes No

Medco Group Number (Commercial): MVPCOMM

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Please complete the following information:

Drug Requested (check one):

Lupron Depot	11.25MG	<input type="checkbox"/>	Lupron Depot-Ped	11.25MG	<input type="checkbox"/>
Lupron Depot	22.5MG	<input type="checkbox"/>	Lupron Depot-Ped	15MG	<input type="checkbox"/>
Lupron Depot	3.75MG	<input type="checkbox"/>	Lupron Depot-Ped	7.5MG	<input type="checkbox"/>
Lupron Depot	7.5MG	<input type="checkbox"/>			

Diagnosis: _____ ICD-9 Code: _____

First Injection Date: _____

Number of Refills: _____

Ship To:

PROVIDER NAME _____

ADDRESS _____

FAX THIS REQUEST TO:
Pharmacy Solutions at 1-800-605-8592
 For additional information, call **1-800-689-9093**

For Internal Use Only

Order #: _____ Ship: _____ Rx: _____

TapCare Rep: _____ VC: _____ Territory: _____