

LUPRON (LEUPROLIDE ACETATE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____

Allergies: _____

DIAGNOSIS (Provider must specify)

Advance prostatic cancer, ICD 10: C61. _____

Endometriosis, ICD 10: _____

Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO

Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE
Lupron	<input type="checkbox"/> 7.5 mg every 4 weeks <input type="checkbox"/> 22.5 mg every 12 weeks <input type="checkbox"/> 30 mg every 16 weeks <input type="checkbox"/> 45 mg every 24 weeks	<input type="checkbox"/> Intramuscular injection

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: NH: 603.217.5371 ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: _____