AcariaHealth™
Specialty Pharmacy

Phone: 866.892.1580 • Fax: 866.892.2363

Date Shipment Needed: ____________ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

CPP REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑**Please attach demographic information**		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis:

❑E30.1- E30.8 Precocious sexual development and puberty, not elsewhere classified / Central Precocious Puberty (CPP) ❑Other: ____________________

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): ____________________
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): ____________________
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: ____________________
- How long should patient wait before starting the new medication? ____________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

____

INSURANCE INFORMATION

❑**Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑**Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

❑**Supprelin® LA (includes implantation kit)**

Insert one implant (50 mg) subcutaneously every 12 months (continuous release of 65 mcg per day) QTY: _____ Refills: _____

- Supprelin LA must be removed after 12 months of therapy, another implant may be inserted to continue therapy if needed
- Discontinuation of Supprelin LA should be considered at the discretion of the physician and at the appropriate time point for the onset of puberty
- Supprelin LA is contraindicated in females who are or may become pregnant

❑**Lupron Depot®-Ped 7.5 mg** (wt: 25 kg or less)
❑7.5 mg IM every 4 weeks ❑Other: ____________________ QTY: __1__ Refills: _____

❑**Lupron Depot®-Ped 11.25 mg** (wt: 25-37.5 kg or less)
❑11.25 mg IM every 4 weeks ❑Other: ____________________ QTY: __1__ Refills: _____

❑**Lupron Depot®-Ped 15 mg** (wt: greater than 37.5 kg)
❑15 mg IM every 4 weeks ❑Other: ____________________ QTY: __1__ Refills: _____

- Discontinuation of Lupron should be considered before age 11 for females and age 12 for males
- Lupron is contraindicated in women who are or may become pregnant

❑**Other:** ____________________ QTY: _____ Refills: _____

Prescriber's Signature: ______________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.