Longs
SPECIALTY PHARMACY

ENDOCRINOLOGY

phone 866.437.6717 fax 866.550.7421
1216 West Main St. • Lexington, SC 29072 **longsrx.com**

DATE: _____ **NEEDS BY DATE:** _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

PATIENT INFORMATION

Patient Name		
Address		
City	State	Zip
Main Phone	Alternative Phone	❑ Male ❑ Female
Social Security #		Date of Birth

PRESCRIBER INFORMATION

Prescriber Name		
Prescriber Type	❑ Physician (MD or DO) ❑ Nurse Practitioner ❑ Physician's Assistant	
Supervising Physician (If prescriber is a NP or PA)		
DEA #	NPI #	Tax ID #
Address		
City	State	Zip
Phone	Fax	
Contact Person		

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

CLINICAL INFORMATION

Diagnosis: ❑ N80.0 Endometriosis ❑ Pelvic Pain ❑ N92.1 Excessive Menstration ❑ D25.9 Uterine Leiomyomata (fibroids)
❑ Premenopausal Ovarian Ablation ❑ C50.919 Breast Cancer ❑ C61 Advanced Prostate Cancer
❑ Other: _____ ❑ ICD-10:

Patient Weight	Patient Height	Bone Density Test Result
❑ Normal Liver Function	❑ Negative Pregnancy Test	Follow Up With Prescriber: ❑ 3 Months ❑ 6 Months ❑ 9 Months ❑ 12 Months
Patient Allergies		
Other Notes/History:		

PRESCRIPTION INFORMATION

			QUANTITY	REFILLS
GYNECOLOGY:				
❑ Lupron Depot® ❑ Lupron Depot - 3®	❑ 3.75 mg ❑ 11.25 mg	❑ Inject intramuscularly (IM) once monthly ❑ Inject intramuscularly (IM) every 3 MONTHS	_____	_____
❑ Norethindrone Tablets	5 mg	Take 1 tablet by mouth once daily	_____	_____
PEDIATRICS:				
❑ Lupron Depot Peds®	❑ 7.5 mg ❑ 11.25 mg ❑ 15 mg	Inject intramuscularly (IM) once monthly	_____	_____
UROLOGY:				
❑ Lupron Depot® ❑ Lupron Depot - 3® ❑ Lupron Depot - 4® ❑ Lupron Depot - 6®	❑ 7.5 mg ❑ 22.5 mg ❑ 30 mg ❑ 45 mg	❑ Inject intramuscularly (IM) once monthly ❑ Inject intramuscularly (IM) every 3 MONTHS ❑ Inject intramuscularly (IM) every 4 MONTHS ❑ Inject intramuscularly (IM) every 6 MONTHS	_____	_____

Dispense As Written (no stamps) **Date** **Substitution Permitted** (no stamps) **Date**

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.
2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.
3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.
4. Prescribers must comply with any of their state-specific prescription requirements.

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