

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Lupron® (leuprolide acetate) or Lupron Depot®**

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of Lupron® (leuprolide) or Lupron® Depot. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number **866-423-0945**

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Patient Name: _____ Date of Request ____/____/____
Member ID#: _____ Date Of Birth: ____/____/____ Pt. Weight (kg): ____
Provider Name: _____ Phone #: _____ Fax#: _____
Contact Person at office: _____

Lupron® is being used for the treatment of _____.

The duration of therapy will be _____.

Information given on this form is accurate as of this date.

Prescriber's signature and NPI

Date