Star Discount Pharmacy specialty care

Women's Health

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name: ______________________ DOB: __________ Gender: ○M ○F Last 4 of SSN:
Address: ________________________ City: ____________ State: ____ Zip: ________ Phone: ___________ Alt. Phone: ___________
Email: ____________________ Ht: ____ Wt: ____ Care Giver: ______________________ Allergies: ○No Known ○See Attached Charts

Prescriber Information: Name: ____________________________ Address: __________________________City: ______________
State: ______ Zip: __________ NPI: ____________________ Phone: _____________ Fax: _____________ Office Contact: ______________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ___________ **ICD-10:** ____________ **Other:** ____________
Is patient pregnant? ○Yes ○No **Confirmed by pregnancy test?** ○Yes ○No
Symptoms Present: ○Dysmenhorrea ○Menorrhagia ○Dyspareunia
○Digestive Complications ○Non-Menstrual Pelvic Pain ○Other: ____________
Diagnostic Procedure: ○Pelvic Exam ○Laparoscopy ○Ultrasound
○MRI ○ Other: ___________________________

Does the patient have osteoporosis?	○Yes	○No
Has impact to bone mineral density been considered?	○Yes	○No
Does the patient have severe hepatic impairment?	○Yes	○No

For Uterine Fibroids:
Does the patient have iron deficiency anemia secondary to uterine fibroids ○ **Yes** ○**No**
HGB: _______ HCT: ________
Will the patient be using concomitant iron supplementation? ○ **Yes** ○**No**
For Lupron: Is this medication being used prior to fibroid surgery? ○ **Yes** ○**No**

Contraindications to Traditional Therapy?

Does the patient have:

Cardiovascular Diseases	○ **Yes** ○**No**
DVT or Embolism:	○ **Yes** ○**No**
Heavy Smoker (≥ 15 cigarettes/day or 35 years old and smoke)	○ **Yes** ○**No**
Peptic Ulcer/Stomach Bleeding	○ **Yes** ○**No**

Contraindications to Intrauterine Devices:

Renal impairment	○ **Yes** ○ **No**
Congenital or acquired uterine anomaly distorting the uterine cavity:	○ **Yes** ○ **No**
History of pelvic inflammatory disease (no subsequent pregnancy):	○ **Yes** ○**No**
Postpartum endometritis or infected abortion in the past 3 months:	○ **Yes** ○ **No**

Prior Failed Treatments	Drug Name & Length of Treatment
○ Aromatase Inhibitors	
○ Combined Hormonal Contraceptives	
○ Contraceptives	
○ GnRH Agonists	
○ NSAIDS	
○ Intrauterine Devices	
○ Iron Supplementation	
○ Opioids	
○ Oral Progestins	
○ Surgery	
○ Tranexamic Acid	
○ Other	

Product Delivery: ○Patient's Home ○Physician's Office ○Pharmacy to Coordinate

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Ref
○ Lupron Depot	○3.75mg Kit	○Inject 3.75mg IM every month	1	
	○11.25mg Kit	○Inject 11.25mg IM once for a three-month treatment course	1	

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)
Signature: ___________________________ Signature_____________________________ Date: ___________
Substitution Permitted **Dispense as Written**
Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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