Endometriosis

Call: (877) 883-1392 Fax: (844) 436-9126

Patient Information: Name:_____ DOB:_____ Gender: ○M ○F

Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____ Caregiver: _____
Email: _____ Height: _____ Weight: _____
Allergies: ○ No Known ○ See Attached Charts ○ Other: _____

Prescriber Information **Please include front and back copies of insurance card.**

Name:_____ NPI: _____
Address: _____ City: _____ State: _____ Zip: _____
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: ○Dysmenorrhea ○Menorrhagia ○Dyspareunia ○ Digestive Complications ○Non-Menstrual Pelvic Pain ○Other: _____
Diagnostic Procedure: ○Pelvic Exam ○Laparoscopy ○Ultrasound ○ MRI ○Other: _____

Prior Failed Treatments	Drug Name & Length of Treatment
○ Aromatase Inhibitors	
○ Combined Hormonal Contraceptives	
○ Contraceptives	
○ GnRH Agonists	
○ NSAIDS	
○ Opioids	
○ Oral Progestins	
○ Surgery	
○ Other	

Contraindications to Traditional Therapy?

Does the Patient have:
○ Cardiovascular Disease ○ Yes ○ No
○ DVT or Embolism ○ Yes ○ No
○ Heavy Smoker (≥ 15 cig/day or 35 years old and smoke) ○Yes ○No
○ Peptic Ulcer or Stomach Bleeding ○ Yes ○ No
○ Renal Impairment ○ Yes ○ No

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

Medication	Dosage & Strength	Directions	Qty	Refills
○ Orilissa	○ 150mg Tablet	○ **Normal liver function or mild hepatic impairment**: 150mg once daily for up to 24 months	28	
		○ **Moderate Hepatic Impairment**: 150mg once daily for up to 6 months	28	
	○ 200mg Tablet	○ **Normal liver function or mild hepatic impairment**: 200mg twice daily for up to 6 months	56	
○				

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.