



## **Endometriosis**

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

			DOD COLLO DA OF		
Patient Information: Name:			DOB: Gender: OM OF		
Address:			City: State: Zip	٠.	
			city state 21, state 21, state 21,		
Email:					
Allergies: O No Known O See Attached Charts O Other:					
Prescriber Information Please include front and back copies of insurance card.					
Name:			NPI:		
			City: State: Zip:		
			ffice Contact:		
Statement of Medical Necessity (Please Attach All Medical Documentation)					
Date of Diagnosis: Symptoms Present: Opysmenorrhea Omenorrhagia Opyspareunia					
ICD-10: Objective Complications One-Menstrual Pelvic Pain Oother:					
Other: Diagnostic Procedure: OPelvic Exam OLaparoscopy OUltrasound					
Is patient pregnant? OYes ONo OMRI OOther:					
Confirmed by pregnancy test? OYes ONo					
		ame & Length of Treatment	Contraindications to Traditional Therapy?		
Aromatase Inhibitors			Does the Patient have:		
Combined Hormonal			○ Cardiovascular Disease ○ Yes ○ No		
Contraceptives  Contraceptives			O DVT or Embolism O Yes O No		
·			○ Heavy Smoker (≥ 15 cig/day or 35 years old and smoke) ○Yes ○ No		
O GnRH Agonists			<ul><li>○ Peptic Ulcer or Stomach Bleeding</li><li>○ Yes</li><li>○ No</li><li>○ Renal Impairment</li><li>○ Yes</li><li>○ No</li></ul>	0	
O NSAIDS					
Opioids			Product Delivery:		
○ Oral Progestins			○ Patient's Home ○ Physician's Office ○ Phari	macy to C	oordinate
○ Surgery			o rutient s riome o ringsician s office o rinari	nacy to c	ooramate
○ Other					
Medication	Dosage & Strength		Directions	Qty	Refills
○ Orilissa		O Normal liver function or mild hepatic impairment: 150mg once daily		28	
	O 150mg Tablet	for up to 24 months			
		O Moderate Hepatic Impairment: 150mg once daily for up to 6 months		28	
		O Normal liver function or mild hepatic impairment: 200mg twice daily for up to 6 months		1	
	○ 200mg Tablet			56	
				1	
0					
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: Date: 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.					
terms of the patient's coverage, among other things, raticipation in this program is not a guarantee of prior authorization of or payment.					

<u>Confidentiality Notice</u>: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.