Star Discount Pharmacy specialty care

urac ACCREDITED Specialty Pharmacy Expires 12/01/2021

ACHC

Women's Health

Call: (877) 883-1392 Fax: (256) 919-0000

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

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**
Renal Impairment	**○Yes**	**○ No**
Contraindications to Intrauterine Devices:		
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**

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

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	

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	
○Oriahnn	○300mg/1mg/0.5mg capsule and 300mg capsule	○ One elagolix, one estradiol, and norethindrone acetate 300mg/1mg/0.5mg capsule in the morning (AM), and one elagolix 300mg capsule in the evening (PM) for up to 24 months	56	
○Orilissa	○150mg Tablet	**Normal liver function or mild hepatic impairment:** ○150mg tablet once daily for up to 24 months	28	
		Moderate hepatic impairment: ○150mg tablet once daily for up to 6 months	28	
	○200mg Tablet	**Normal liver function or mild hepatic impairment**: ○200mg tablet twice daily for 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.

Revised 10/15/2020