

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
 Will the patient be using concomitant iron supplementation? Yes No

HGB: _____ HCT: _____

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

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

Prior Failed Treatments	Drug Name & Length of Treatment
<input type="radio"/> Aromatase Inhibitors	
<input type="radio"/> Combined Hormonal Contraceptives	
<input type="radio"/> Contraceptives	
<input type="radio"/> GnRH Agonists	
<input type="radio"/> NSAIDS	
<input type="radio"/> Intrauterine Devices	
<input type="radio"/> Iron Supplementation	
<input type="radio"/> Opioids	
<input type="radio"/> Oral Progestins	
<input type="radio"/> Surgery	
<input type="radio"/> Tranexamic Acid	
<input type="radio"/> Other	

Prescription Information

Medication	Dosage & Strength	Directions	Qty	Ref
<input type="radio"/> Lupron Depot	<input type="radio"/> 3.75mg Kit	<input type="radio"/> Inject 3.75mg IM every month	1	
	<input type="radio"/> 11.25mg Kit	<input type="radio"/> Inject 11.25mg IM once for a three-month treatment course	1	
<input type="radio"/> Myfembree	<input type="radio"/> 40mg/1mg/0.5mg tablet	<input type="radio"/> One relugolix, one estradiol, and one norethindrone acetate 40mg/1mg/0.5mg tablet orally once daily for up to 24 months.	28	
<input type="radio"/> Oriahnn	<input type="radio"/> 300mg/1mg/0.5mg capsule and 300mg capsule	<input type="radio"/> 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.

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