



## 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

**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 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	
<input type="radio"/> Orilissa	<input type="radio"/> 150mg Tablet	<b>Normal liver function or mild hepatic impairment:</b> <input type="radio"/> 150mg tablet once daily for up to 24 months	28	
		<b>Moderate hepatic impairment:</b> <input type="radio"/> 150mg tablet once daily for up to 6 months	28	
	<input type="radio"/> 200mg Tablet	<b>Normal liver function or mild hepatic impairment:</b> 200mg <input type="radio"/> 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.

